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ABSTRACT

This report examines Federal government activities undertaken to support adult female victims of spouse abuse in 1979 and 1980, summarizes issues that must be resolved to improve national, State, and local responsiveness to the problems of spouse abuse, and suggests legislative, regulatory, and administrative changes. The needs of victims of domestic violence and of the organizations that serve them are assessed for the following areas: (1) housing; (2) social services; (3) financial; (4) legal; (5) physical and mental health; (6) employment and training; and (7) organizational development and management. Nineteen Federal Programs existing in 1979-80 are examined to determine their relevance, adequacy, and potential for meeting the identified needs, with emphasis on how current legislation and administrative policy enhance or inhibit the potentials of these programs to serve victims of domestic violence. Other Federal programs are briefly discussed to illustrate Federal resources available to State and local organizations for addressing the needs of battered women. Appended are an explanation of the methodology used in collecting the information in the report, and descriptions of the Federal programs studied. (Author/MJL)

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The Federal Response to Domestic Violence

A Report of the United States Commission on Civil Rights

January 1982

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- Investigate complaints alleging that citizens are being deprived of their right to vote by reason of their race, color, religion, sex, age, handicap, or national origin, or by reason of fraudulent practices;
- Study and collect information concerning legal developments constituting discrimination or a denial of equal protection of the laws under the Constitution because of race, color, religion, sex, age, handicap, or national origin, or in the administration of justice;
- Appraise Federal laws and policies with respect to discrimination or denial of equal protection of the laws because of race, color, religion, sex, age, handicap, or national origin, or in the administration of justice;
- Serve as a national clearinghouse for information in respect to discrimination or denial of equal protection of the laws because of race, color, religion, sex, age, handicap, or national origin;
- Submit reports, findings, and recommendations to the President and the Congress.

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The Federal Response to Domestic Violence

A Report of the United States Commission on Civil Rights
January 1982

Letter of Transmittal

U.S. Commission on Civil Rights
Washington, D.C. 20425
January 1982

THE PRESIDENT
THE PRESIDENT OF THE SENATE
THE SPEAKER OF THE HOUSE OF REPRESENTATIVES

Sirs:

The United States Commission on Civil Rights transmits this report to you pursuant to Public Law 85–315, as amended.

This report evaluates Federal agency efforts to address the needs of adult female victims of domestic violence and the local community organizations that serve them. The information contained in this document was obtained from discussions with local service providers, interviews with Federal agency program staff, and a review of literature on domestic violence.

The report specifically identifies the major needs of battered women, as well as those of the organizations that provide for their needs. It asseses the adequacy and relevance of Federal support. The report reviews 19 major Federal programs in effect during the period examined, 1979–1980, that illustrate the range and variety of Federal resources which can respond to the needs of victims of spouse abuse. It also briefly describes several Federal initiatives on domestic violence then in effect. This report serves as a historical survey of the Federal response to battered women, providing guidance to Federal, State, and local program administrators in channeling the future use of Federal resources for domestic violence.

An overall finding of this report is that the use of Federal programs in addressing domestic violence is relatively recent and, in large part, sporadic. Nevertheless, service structures and mechanisms within Federal programs have been used, and can be used, to meet the needs of battered women. Another finding is that, in several instances, Federal programs provided assistance to efforts on behalf of battered women at local and State levels, where decisions on priority use of Federal funds are often made. A third finding is that the public, agents of the justice systems, medical personnel, social service providers, and researchers are generally unaware of the extent and seriousness of the problem of domestic violence.

The report concludes that if a Federal response to battered women is to be maintained, Federal agencies must reassess their authority and develop more creative and effective uses of diminishing resources in cooperation with State and local agencies. Several recommendations are made to maintain and increase the Federal response to battered women and the organizations that serve them within the current authorities of the Federal programs and as a complement to State and local efforts.

The Commission is hopeful that the suggestions offered in this report will assist Federal and State agencies, as well as local service providers, in their efforts to respond to the serious and often life-threatening situations of women who are victims of domestic violence.

Respectfully,

Arthur S. Flemming, *Chairman*
Mary F. Berry, *Vice Chairman*
Stephen Horn
Blandina Cardenas Ramirez
Jill S. Ruckleshaus
Murray Saltzman

John Hope III, *Acting Staff Director*

Preface

The U.S. Commission on Civil Rights has a legal mandate to study and collect information "and to appraise the laws and policies of the Federal Government with respect to discrimination or denials of equal protection of the laws. . .in the administration of justice."[1] Over the last few years, the Commission has examined the issue of domestic violence, particularly the response of legal and social service systems to the distinct needs of women who are physically abused by their husbands or mates.[2] This examination has occurred; at the local, State, and national levels with the recognition that resolution of this issue entails national level support of existing local and State efforts to prevent domestic violence and to assist its victims.

At the local level, hearings were held in Phoenix, Arizona, in February 1980 and Harrisburg, Pennsylvania, in June 1980 that focused on the handling of incidents of domestic violence by the civil and criminal justice systems. Information obtained from these hearings provided the basis for the national Commission report on *Battered Women and the Administration of Justice.*

At the State level, four of the Commission's State Advisory Committees have issued reports based on State and local responses to battered women. In August 1977, the Colorado Advisory Committee to the Commission issued a report entitled *The Silent Victims: Denver's Battered Women,* which concluded there was a high incidence of wife beating, a lack of services for victims, and a paucity of reliable data and statistical information on the problem. It also concluded that criminal action was rarely taken against batterers due to breakdowns in the legal processes in family violence cases; conversely, fearing publicity, many women never avail themselves of the criminal justice process. The Colorado Advisory Committee has also prepared a film entitled "A Woman, A Spaniel, and a Walnut Tree," which documents the problem faced by battered women in Denver, as well as across the Nation.

In April 1979 The Connecticut Advisory Committee to the Commission issued a

[1] 42 U.S.C. 1975c(a)(2), (3) (Supp. III 1979).

[2] Although it is true that men are sometimes the targets of spouse battering, this report, as well as prior Commission reports, focuses on female victims for several reasons. The incidence of abuse of women by men is much greater than the abuse of men by women. Women are, as a group, more likely to be economically dependent upon their spouses and therefore unable to escape an abusive relationship without protection from the legal system and support from various service organizations. Finally, the common law legacy of women as objects of property and as incompetents unable to conduct their own legal affairs continues to color the attitudes of police officers, prosecutors, judges, and providers of social services needed by battered women.

report entitled *Battered Women in Hartford, Connecticut,* which concluded that despite growing public awareness of the problems of battered women, most criminal justice and social service agencies in Hartford do not, at present, provide the assistance needed by these women. The research indicated that the police and courts do not always treat battering with the seriousnes it deserves, and that staff throughout the criminal justice and social service agencies are not always adequately trained to handle the problems of these women. Public funds to make available the necessary services were also found to be inadequate.

The New Hampshire Advisory Committee to the Commission held a consultation on battered women in June 1979 to examine whether State and local government were providing physical safety to citizens without discrimination. Evidence presented at the consultation indicated that such protection was often less available to persons in marriages or conjugal relationships than to other citizens. In the overwhelming number of cases, it was the female partner who was at risk of being denied full protection of the law.

The New Jersey Advisory Committee to the U.S. Commission on Civil Rights issued a report entitled *Battered Women in New Jersey* in January 1981. This report concluded that despite increased attention to the plight of battered women, they continued to face severe problems. The Advisory Committee found that the New Jersey criminal justice system generally failed to provide meaningful assistance to battered women and that there was a shortage of support services.

At the national level, the Commission held a consultation in Washington, D.C. in January 1978 entitled *Battered Women: Issues of Public Policy.* During this 2-day meeting, testimony was presented to, and discussed by, the Commissioners and a panel of experts, including attorneys, academicians, local shelter program staff, and representatives of the Federal Government. The consultation was intended to define the problems relating to battered women and to address their potential solutions; more specifically, the objectives were:

> to identify sound, existing research data, as well as research gaps, and consequently, to consider research strategies; to identify necessary State legal and law enforcement reform; to identify needed short- and long-term support services for battered women; to identify, in all the above, the appropriate Federal role; to facilitate communication among researchers, activists, policymakers, and others; and to inform the public.

Among the salient points brought out in the consultation, in addition to the magnitude of the problem and the need for more services, were the following:

1. The effects of wife beating on the victim, the batterer, their children, and society at large are severe. Direct physical consequences for the victim may include bruises, concussions, hemorrhages, burns, broken bones, and death. Abusers, in turn, may receive severe or fatal injuries from their victims who, lacking the physical strength to fight back, may defend themselves with weapons. Children, if not abused themselves, may be conditioned to accept or perpetrate abusive behavior or be terrorized to the point of extreme psychological damage.
2. The problem is exacerbated by many commonly held attitudes and assumptions. Among these are the assumptions that men have a right to chastise their wives through physical force, that a woman who remains in an abusive situation could easily leave if she really wanted to.
3. The abused woman often has no viable alternative to remaining in an abusive situation. Fearing pursuit and reprisal by her husband, having no safe place to go,

concerned for the welfare of her children, and suspecting that legal remedies rarely lead to any long-term change, she feels she has no choice but to make the best of a situation that usually worsens.

4. Helping professionals, including doctors, police, social workers, and psychologists, generally lack the knowledge and training necessary to address the problem of spouse abuse. In addition, they often feel uncomfortable in becoming involved in a problem they see as a private one. As a result, they often fail to identify cases of abuse, ignore them, or only treat their most superficial symptoms.

5. In general those local services that have sprung up to serve battered women are in desparate need of financial support, training, and technical assistance.

The power, clarity, and unanimity of the consultation testimony, combined with the outpouring of support from grassroots organizations throughout the country, convinced the Commission that strong action must be taken. The unmistakable conclusion of the consultation, and previous Commission reports, was that there is a need for national coordination and support of the existing, largely local, fragmented efforts to serve the adult victims of domestic violence.

Accordingly, in August 1980, the Commission endorsed S. 1843, "The Domestic Violence Prevention and Services Act," to encourage increased participation of States, local communities, nonprofit private organizations, and individual citizens in the effort to prevent and respond to domestic violence. Further, the Commission urged provisions for encouraging increased State and local interagency coordination and for stimulating the development or revision of State policies and programs to provide meaningful assistance to victims of domestic violence.

The present report and its companion study, *Battered Women and the Administration of Justice,* are the culmination of the Commission's comprehensive investigation of domestic violence. Taken together, they delineate the major service delivery and administration of justice issues in domestic violence. This report, *The Federal Response to Battered Women,* emphasizes the support services needed by battered women and the organizations that provide these services to them. It specifically identifies the major needs of battered women and of organizations that serve them and assesses the adequacy and relevance of Federal support for needed services during 1979–80. The study reviewed 19 Federal programs in depth that did or could respond to the major needs of battered women during the study period.

The complementary study, *Battered Women and the Administration of Justice,* analyzes existing laws, judicial trends, and legislative reforms that address (either by affirming or denying) the civil rights of battered women. It provides the Commission with an indication of whether battered women are equitably treated by the various institutions of the civil and criminal justice systems.

Taken together, the findings and recommendations of both reports constitute a comprehensive national strategy for addressing domestic violence in concert with and supportive of State and local efforts.

Acknowledgments

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The study originated in the Commission's former Women's Rights Program Unit and was completed in the Office of Program Planning and Evaluation. Juanita Tamayo Lott served as contract manager. Contributions were made by Martha Jones and Sylvia Eastman subsequent to external and internal review. Support was provided by Sheila Lyon. Eugene Platt edited the report and preparations for publication were handled by Vivian Hauser, Audree Holton and Vivian Washington. This project was accomplished under the overall supervision of Carol A. Bonosaro, Assistant Staff Director for Congressional and Public Affairs, except for final review and completion of the report, which was supervised by Eugene S. Mornell, Assistant Staff Director for Program Planning and Evaluation.

Contents

1. Introduction 1
Scope and Methods 2

2. Housing 4
Assessment of Housing Needs. 4
Emergency Housing
Transitional or Short-Term Housing
Long-Term Housing
Needs of Shelter Programs
Selected Federal Programs Addressing Housing Needs 6
Core Programs
Community Development Block Grant Program
Lower Income Housing Assistance Payments Programs
Other Relevant Programs
AFDC Emergency Assistance
Bureau of Indian Affairs Social Welfare Programs
LEAA National Priority and Discretionary Grants Programs
Department of Defense
Title XX
Community Action Programs
Public Housing
Urban Development Action Grants
Urban Homesteading
Rural Rental Assistance Payments
Disposal of Federal Surplus Real Property

3. Social Services 10
Assessment of Social Services Needs 10
Direct Services, Advocacy, and Coordination of Services
Services to Children
Selected Federal Programs Addressing Social Services Needs 12
Core Programs
Title XX of the Social Security Act
Community Action Programs
Bureau of Indian Affairs Social Welfare Programs
Other Relevant Programs

Child Abuse and Neglect Prevention and Treatment
DHHS Native American Programs
Community Development Block Grant Program
Comprehensive Employment and Training Act—Special Programs and Activities for the Disadvantaged
Law Enforcement Assistance Administration National Priority and Discretionary Grants Program
Office of Juvenile Justice and Delinquency Prevention—Special Emphasis Prevention and Treatment Programs, Formula Grant Programs

4. Financial Assistance 17
Assessment of Fianancial Assistance Needs 17
Emergency Assistance
Ongoing Financial Assistance
Selected Federal Programs Addressing Financial Assistance Needs 19
Core Program: Aid to Families with Dependent Children
Other Relevant Programs
Food Stamps
Medicaid

5. Legal Services 23
Assessment of Legal Needs 23
The Criminal Justice System
The Civil Justice System
Training and Education
Advocacy and Legal Assistance
Selected Federal Programs Addressing Justice Needs 30
Core Programs
Legal Services Corporation
Law Enforcement Assistance Administration: National Priority Grants Program and Discretionary Grants Program
Law Enforcement Assistance Administration: Formula Grant Program
Other Relevant Programs
AFDC Emergency Assistance
Bureau of Indian Affairs Social Welfare Programs
Community Development Block Grant Program
Title XX
National Institute of Justice
Bureau of Justice Statistics
Office of Juvenile Justice and Delinquency Prevention
National Institute of Corrections

6. Mental Health 36
Assessment of Mental Health Needs 36
Training of Mental Health Professionals
Crisis Intervention
Short- and Long-Term Counseling Support
Prevention
Research
Selected Federal Programs Addressing Mental Health Needs 40
Core Programs

Community Mental Health Centers
Alcoholism Prevention, Treatment, and Rehabilitation
Drug Abuse Prevention and Treatment
Other Relevant Programs
Community Health Centers
Department of Defense
Veterans Administration
Community Development Block Grants
Law Enforcement Assistance Administration
Title XX
National Center on Child Abuse and Neglect

7. Health 45
Assessment of Health Needs 45
Need for Emergency Treatment
Need for Ongoing Medical Care
Selected Federal Programs Addressing Health Needs 48
Core Programs
Community Health Centers
Department of Defense
Veterans Administration Hospitalization and Outpatient Service Programs
Other Relevant Programs
Public Health Service Formula Grants
Migrant Health Grants
Maternal and Child Health Services DHHS
Indian Health Services
Family Planning Projects

8. Employment and Training 54
Assessment of Employment, Training, and Education Needs 54
Provision of Prevocational Programs
Development of Individual Employment Plans
Provision of Day Care
Development of Linkages with Community Resources
Selected Federal Programs Addressing Employment, Education, and Training Needs 56
Comprehensive Employment and Training Act (CETA)
Other Relevant Programs
Community Action Agencies
Title XX of the Social Security Act
U.S. Employment Service
Work Incentive Program

9. Organizational Development and Management 58
Assessment of Organizational Needs 58
Program Planning Needs
Resource Development
Establishment of a Rational Program Planning Process
Technical Skills Development
Community Coordination and Advocacy
Community Coordination

Community Awareness/Education
Statewide and National Advocacy
Selected Federal Programs Addressing Organizational Needs 61
Core Programs
Donated Surplus Personal Property Program
Volunteers in Service to America
Food Donation Program
Other Relevant Programs
Title XX Social Services
Community Action Programs

10. Specific Federal Initiatives 65
Office on Domestic Violence 65
Scope of the Initiatives
Interdepartmental Committee on Domestic Violence 67
Defense Department 68
Center for Studies of Crime and Delinquency 69
Organizational Structure
Scope of the Initiative
Funding

11. Legislative Directions in Spouse Abuse 72

12. Common Issues 77

Appendix A—Methodology 85

Appendix B—Federal Program Descriptions 93
Aid to Families with Dependent Children 93
Bureau of Indian Affairs Social Welfare Programs 98
Donation of Federal Surplus Personal Property to Public Agencies and Nonprofit Educational and Public Health Institutions and Organizations 101
Lower Income Housing Assistance Payments Program 104
Community Development Block Grant Program 109
Legal Services Corporation 113
Law Enforcement Assistance Administration, National Priority Grants Program and Discretionary Grants Program 116
Law Enforcement Assistance Administration, Formula Grant Program 119
Comprehensive Employment and Traning Act 123
Food Donation Program 126
Community Health Centers Program 129
Community Action Programs 134
Volunteers in Service to America 138
Veterans Administration, Hospitalization and Outpatient Services Program 140
Community Mental Health Centers 144
Alcoholism Prevention, Treatment, and Rehabilitation 148

Drug Abuse Prevention and Treatment 152
Department of Defense 157
Social Services for Low-Income Persons and Public Assistance Recipients 163

Appendix C—Analysis of the Domestic Violence Prevention and Services Act 168

Chapter 1

Introduction

Although there has been increasing research in domestic violence over the past few years, the extent of the problem is still unknown. A recent national study of 2,143 couples found that:

> in the 12 months prior to the interview, 3.8 percent of these couples reported one or more physical attacks by the husbands which were serious enough to fall into [the] category of wife-beating. [Applying this incidence rate to the approximately] 47 million couples in the United States [means that] in any one year about 1.8 million wives are beaten by their husbands.[1]

Results of a recent survey in Kentucky sponsored by the Law Enforcement Assistance Administration indicate that, in the 12 months before the survey, 10 percent of the female partners surveyed had experienced some degree of spousal violence at some time in their lives.[2]

"Spouse violence" was interpreted to include throwing an object, pushing, grabbing, shoving, slapping, kicking, biting, hitting with a fist or other object, beating up, threatening with a knife or gun, and use of a knife or gun. No significant differences in incidence were shown among income and education groups, although incidents involving women of low income and low education were reported to police much more frequently than those involving the middle class and the better educated. Also, the survey showed that there is a wide gap between the services and treatment received by victims of spousal violence and the services they would like to have received:

- In 34 percent of the cases these women wanted counseling, but only 5 percent received it.
- In 26 percent of the cases women with children wanted child care, yet only 1 percent received it.
- In 27 percent of the cases the women wanted legal aid, but it was provided in only 2 percent of the cases.
- Emergency shelter would have been welcome in 25 percent of the cases, but was provided in only 2 percent.

The physical abuse of women by their husbands or male companions constitutes a civil rights problem of overwhelming magnitude that, until 4 or 5 years ago, was virtually ignored by every branch of the Federal Government. It has been estimated that the problem affects almost two million women in the United States each year,[3] extending to all ethnic groups and income levels, and often trapping the victims in situations that pose a tangible threat to life and well-being.

This report examines the Federal Government's activities in support of adult female victims of "spouse abuse" (or "wife battering") in 1979 and 1980, summarizes the issues that must be resolved to improve national responsiveness to the problems of spouse abuse and to facilitate local and State efforts in these areas, and suggests legislative, regulatory, and administrative changes that can be undertaken

[1] Murray Straus, "Wife Beating: Causes, Treatment, and Research Needs," in *Battered Women: Issues of Public Policy* (proceedings of a consultation sponsored by the U.S. Commission on Civil Rights, January 1978), p. 153.

[2] Mark A. Schulman, *A Survey of Spousal Violence Against Women in Kentucky* (conducted for Kentucky Commission on Women, Louis Harris and Associates, Inc., July 1979).

[3] Straus, "Wife Beating: Causes, Treatment and Research Needs," p. 153.

to improve the Federal response to this social problem.

Since the data were collected and analyzed, questions concerning the appropriate and efficient role and responsibility of the Federal Government have surfaced. Changes in Federal program responsibilities and reductions in the Federal budget have been requested by the current administration.[4] Some of the agencies examined in this report are proposed for termination.[5] Similarly, some of the programs reviewed are proposed for reorganization, reduction, or cancellation.[6] Furthermore, specific initiatives on domestic violence underway in 1979 and 1980 (such as the Office of Domestic Violence in the Department of Health and Human Services) have been or will soon be terminated, their functions subsumed under more traditional programs or offices.[7] In short, the Federal, and, consequently, State and local response to human services issues is in a state of flux.

This is not to say that there can be no Federal response to domestic violence and other human services issues. It does mean more creative and effective use of Federal resources that complement and support State and local efforts. In view of these events, this report serves not only as a historical survey of the Federal response to battered women in 1979 and 1980, but it also demonstrates the range and flexibility of Federal resources available to State and local groups and provides guidance to Federal, State, and local program administrators in channeling the use of Federal resources for domestic violence.

Scope and Methods

The success of efforts to prevent wife battering rests upon many issues: societal attitudes about women, social and economic opportunities for women, and our notions about the basic institutions of marriage and the family, particularly women's roles and rights in them. Consideration of these issues is crucial to a full understanding of the problem of wife abuse, but this report has the narrower focus of examining ways that the Federal Government can meet the need of women who have been battered by providing support to shelters and local organizations that serve them. While recognizing the broader context of domestic violence that includes male spouse, child, and even elderly abuse, this report focuses on female spouse abuse and the needs of its victims. The terms "wife battering" and "spouse abuse" are used interchangeably throughout the report to refer to the abuse of adult female partners in a marital relationship whether or not that relationship is legally recognized. The term "domestic violence" is reserved for the broader notion of violence among various members of the family.

The first major task of the study was to identify the most important needs of victims of domestic violence and the organizations that serve them. This was accomplished through a needs assessment that included a literature review and telephone consultations with experts in the field. Respondents participating in the telephone consultations included shelter directors, directors of community agencies that serve battered women, researchers, and representatives from State and national task forces on battered women. The telephone consultations focused on broad subject areas, including victim needs, agency needs, funding sources, and barriers to obtaining Federal funding. A detailed discussion of the needs assessment methodologies is contained in appendix A, "Methodology," of this report.

The second major task involved an assessment of 19 Federal programs in existence in 1979–1980 to determine their relevance, adequacy, and potential for meeting the identified needs. The assessment was conducted by interviewing Federal agency staff and by reviewing relevant documentation such as legislation, regulations, guidelines, financial reports, and administrative doctrines. The scope of this study did not allow for field visits to local agencies to obtain information on the effectiveness of these programs in meeting needs at the local level. Rather, the focus is on how legislation, regulations, and administrative policy currently enable or inhibit the potential of

[4] The White House, "Budget Reform Plan," in *America's New Beginning: A Program for Economic Recovery* (Washington, D.C.: Executive Office of the President), Feb. 18, 1981).

[5] Office of Management and Budget, *Fiscal Year 1982 Budget Revisions* (Washington, D.C.: Executive Office of the President, March 1981). For example, authorized activities of the Community Services Administration are proposed for administration under the Health and Human Services Social Services Block Grant. The Community Services Administration was terminated on September 30, 1981.

[6] The White House, "Budget Reform Plan." Programs slated for reduction include AFDC welfare programs and CETA public service jobs.

[7] As of January 1981, the functions of the Office of Domestic Violence were transferred to the National Center for Child Abuse and Neglect, DHHS.

these programs to support shelters and organizations that serve victims of domestic violence.

The 19 programs were selected on the basis of criteria that included relevance to a major area of need, substantial program dollars, flexibility in the use of funds to meet needs, accessibility of funding to shelters, and past and current initiatives in the area of domestic violence. The Federal programs selected for analysis were:

1. Alcohol treatment and rehabilitation (National Institute on Alcohol Abuse and Alcoholism—NIAA), Department of Health and Human Services (DHHS)

(Note: The former Department of Health, Education, and Welfare was reorganized to form DHHS and the Department of Education.)

2. Assistance payments—maintenance assistance (Aid to Families with Dependent Children—AFDC)
3. Community action program (Community Services Administration—CSA)
4. Community development block grants (entitlement/small cities) (Housing and Urban Development—HUD)
5. Community health centers (DHHS)
6. Community mental health centers (DHHS)
7. Comprehensive employment and training program (Department of Labor)
8. Department of Defense program (DOD)
9. Donation of Federal surplus personal property (General Services Administration—GSA)
10. Drug abuse community service programs (Alcohol, Drug Abuse, and Mental Health Administration—ADAMHA) (DDHS)
11. Food distribution program (Department of Agriculture)
12. Law enforcement assistance—formula grants program (Department of Justice)
13. Law enforcement assistance—national priority grants program and discretional grants program (Department of Justice)
14. Legal Service Corporation
15. Lower income housing assistance programs (Section 8) (HUD)
16. Native American programs (Bureau of Indian Affairs)
17. Social services for low-income and public assistance recipients (Title XX) (DHHS)
18. Veterans Administration—hospitalization and outpatient care
19. Volunteers in Service to America (VISTA)

In addition to the 19 "core" programs, other Federal programs were identified during the course of the study that appeared to have potential for meeting one or more of the identified areas of need. Although it was beyond the scope of this study to analyze these programs in detail, they are briefly discussed in the report because they are illustrative of the Federal resources available to State and local organizations in addressing the needs of battered women. For a more detailed description of the methodology see appendix A.

Any assessment of Federal response to the victims of domestic violence must be keyed to their most important needs. The needs assessment produced eight areas of need by the victims and those who serve them. They are:

Housing
Social services
Financial
Legal
Mental Health
Health
Employment and training
Organizational development and management

Chapters 2–9 address each of these needs and the Federal programs that are relevant to them.

Chapters 10, 11, and 12 deal with, respectively, specific Federal initiatives, legislative directions in spouse abuse, and common issues.

Chapter 2

Housing

Assessment of Housing Needs

In the telephone consultations with shelter staff and other experts in the field of wife battering, housing was identified frequently as a priority need of victims. The battered woman is faced with a housing crisis in her attempt to protect herself and her children from further abuse, in her search for space to live while she considers future options, and in her need for separate housing if she decides to leave her husband or companion. These factors contribute to the need for different stages of housing—emergency shelter, short-term or transitional housing, and long-term housing.

Accommodating the victim's housing needs is a major focus of many local programs for battered women. According to the Center for Women Policy Studies, Washington, D.C., over 300 shelters were in operation throughout the country in 1979–1980; yet the responses from the needs assessment indicate that the need for housing far outweighs the availability of current resources.

Emergency Housing

Battered spouses often require immediate shelter for their safety and well-being. Lenore Walker points out that safe houses, refuges, or shelters have "become the cornerstone of treatment for battered women who do not wish to return [home]."[1] Del Martin states that "Victims and their children need refuge from further abuse; any other consideration is of secondary importance."[2] Although emergency shelter is essential to the immediate safety of the victim and children, the scarcity of such facilities in relation to the demand is apparent. Many victims of violence continue to live at home under the threat of more violence because they have no other place to go. A West Coast-based shelter staff member stated in recent testimony before the Subcommittee on Select Education of the House Committee on Education and Labor:

> Three years ago there was one shelter for battered women in the Los Angeles area and it received 100 calls a month. Today there are seven shelters and each one of them averages up to 300 calls a month! All shelters turn away many more women and children than they can accept. As many as 15 clients cannot be served for every 1 finding space available.[3]

Transitional or Short-Term Housing

The amount of time a woman can spend in a shelter or safe home varies. Lenore Walker states, "Most shelters in this country find between 4 and 6 weeks to be the optimum stay. It takes 3 or 4 weeks for a woman to adjust to the fact that she is not going home."[4]

However, a review of the shelter services listed by the Center for Women Policy Studies indicates that

[1] Lenore Walker, *Battered Women* (New York: Harper and Row, 1979), p. 195.

[2] Del Martin, *Battered Wives* (San Francisco: Glide Publications, 1976), p. 197.

[3] Geraldine Stahly, executive director, Women's Shelter, Long Beach, Calif., testimony before U.S. Congress, House Committee on Education and Labor, Subcommittee on Select Education, July 10, 1979, p. 3.

[4] Walker, *Battered Women*, p. 196.

several shelters across the country can only provide housing during the first few days after the victim leaves home. Some shelters can only allow a 32-hour stay because of limited available space and a large demand for services.[5] An article in the newsletter *Response* noted, "Financial and spatial limitations have forced shelters to curtail the length of stay of each client, in order to accomodate others who need crisis assistance."[6] Some form of transitional housing is needed to fill the gap between the few days that an emergency shelter can provide and the several weeks that a woman may need to make a more permanent adjustment.

According to the telephone consultation respondents, when victims are unsuccessful in finding alternative living arrangements, they often return home where they are again abused. When the abuse again becomes intolerable, they seek the services of the emergency shelter once more.

Long-Term Housing

Long-term housing is needed after the initial emergency shelter or short-term housing period has elapsed. A program guide developed by the State of New Jersey states, "Even when the woman has made the decision to leave her husband/companion, she still faces the problem of adjusting to living on her own."[7]

Respondents cited the need for "second-stage" or long-term housing, but differed in their definition of this term. Some described second-stage housing as a protected environment similar to a shelter but one that allows a longer stay. Supportive services such as job training are provided to help women prepare for independent living. Other respondents defined second-stage housing as an independent living situation in the community. There is agreement, however, on the lack of avialable long-term housing, especially for single women with children and for those with limited incomes. Respondents also pointed out that a battered woman's options for housing may be even further limited if she is trying to conceal her place of residence from her husband. Moving to a new and unfamiliar community may be necessary.

Several interviewees stated that they worked with their local housing authorities in an effort to secure low-income housing for victims. However, lengthy waiting lists limit public housing as an option for battered women.

Dr. Walker summarized the problems of women searching for long-term housing:

> At first glance, it would appear that in this country housing is not such a severe problem. In the United States, with a capitalistic form of government, women supposedly can go out and rent an apartment without having to wait on a government housing list. This is not necessarily true. This system has other ways of excluding people; it is often very difficult for women with children to obtain apartments and housing. Likewise women living together, minority women and women on public assistance experience discrimination. High costs are another deterrent for most women. In places where subsidized housing is available, there are often long waiting lists. It is not uncommon for there to be a two-year waiting list for the HUD rent subsidy program. Women whose ex-husbands are in a high-income bracket often do not qualify for the few programs that are available. Welfare regulations which prevent the issuance of monies—for rent security deposits and furniture present another obstacle in the establishment of an independent household.[8]

Needs of Shelter Programs

Testifying before the House Subcommittee on Select Education, Richard Fleming, HUD's General Deputy Assistant Secretary for the Office of Neighborhoods, Voluntary Associations, and Consumer Protection, stated:

> A recent survey of over 300 Battered Women's Shelters conducted by the Colorado Association of Aid to Battered Women reports that shelters are generally overcrowded, the scarcity of housing has resulted in the use of apartments, motels and hotels as well as converted private residences. Many of these physical facilities present problems in terms of adequate communal space, appropriate facilities for children and excessive costs.[9]

Respondents frequently supported this statement in describing the lack of sufficient space in shelters and the need for building repairs and renovation.

[5] Center for Women Policy Studies, "Program Providing Services to Battered Women," June 1979.

[6] *Response*, Center for Women Policy Studies, vol. 2, no. 9 (August 1979), p. 1. (hereafter cited as *Response*).

[7] State of New Jersey, Department of Human Services, Division of Youth and Family Services, "Physically Abused Women and Their Families: The Need for Community Services," June 1, 1978, p. 25.

[8] Colorado Association for Aid to Battered Women, *A Monograph on Services to Battered Women* (HEW Publication No. (DHDS) Dec. 12, 1978), (hereafter cited as Denver Monograph).

[9] Richard Fleming, General Deputy Assistant Secretary, HUD, testimony before U.S. Congress, House Committee on Education and Labor, Subcommittee on Select Education, July 11, 1979, p. 1.

They also pointed out that much staff time is devoted to helping battered women find suitable housing after they leave the shelter. As mentioned previously, victims often return to the abusive situation because no alternative housing is available and then seek the shelter service again when the abuse becomes intolerable. This revolving door phenomenon decreases staff morale and leads to worker "burnout."

Although Federal funds are available to shelters for rehabilitating their facilities, respondents considered that decisions on the use of Federal housing funds were based on local politics rather than program need and merit. They said that technical assistance is needed to help shelters apply for Federal housing funds. Some of the problems cited in establishing a shelter include changing local zoning ordinances, obtaining special-use building permits, and convincing local government that domestic violence projects should be a part of overall community proposals submitted to HUD.[10]

Selected Federal Programs Addressing Housing Needs

Core Programs

Community Development Block Grant Program

The community development block grant program (CDBG) was established in the Department of Housing and Urban Development (HUD) by Title I of the Housing and Community Development Act of 1974.[11] The primary purpose of the CDBG program was "the development of viable urban communities, by providing decent housing and a suitable living environment and expanding economic opportunities, principally for persons of low and moderate income."[12]

Through the CDBG program eligible cities and counties receive HUD funds for a wide variety of community development activities. which are detailed in a 3-year plan submitted by the community to HUD. (See appendix B for a detailed discussion of the CDBG program.)

The CDBG program is meant to provide considerable flexibility to officials in communities eligible for either entitlement grants or the small cities program (HUD). A recent amendment to the regulations governing the CDBG program is of particular importance to the housing needs of battered women. Section 570.202, "Eligible rehabilitation and preservation activities," states in part:

> Grant assistance may be used for the following activities for the rehabilitation of buildings and improvements: (a) Rehabilitation of public residential structures. Rehabilitation of publicly owned or acquired properties for use or resale in the provision of housing including: (2) Residential facilities, including group homes, halfway houses, and emergency shelters. For example, a group home for the handicapped or a temporary shelter for battered persons may be provided through acquisition and rehabilitation of properties for those purposes.[13]

The same section of the regulations stipulates that CDBG funds can also be used for public housing modernization, rehabilitation of private properties (including acquisition for the purpose of rehabilitation), temporary relocation assistance to families and organizations displaced by rehabilitation activities, code enforcement, and historic preservation.[14]

Nonprofit organizations may receive block grant funds for these activities from local units of government.[15] Eligible organizations under this section include private, nonprofit entities, neighborhood-based nonprofit organizations, local development corporations, or small business investment companies.[16] These organizations may receive CDBG funds:

> for activities otherwise eligible for block grant assistance pursuant to 570.201–570.203. . . .Where such entities use block grant funds to acquire title to facilities. . .they shall be operated so as to be open for use by the general public during all normal hours of operation. Reasonable fees may be charged. . .but charges. . .which will have the effect of precluding low- and moderate-income persons from using the facilities are not permitted.[17]

As of September 1980 over 60 shelters were receiving some CDBG funding.[18] These grants

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[10] *Response*, vol. 3, no. 3 (November 1979), p. 2.
[11] 42 U.S.C.A. §§5301–18 (1977 and Supp. 1980).
[12] *Id.*, §5301(c).
[13] 24 C.F.R. §570.202(a)(1979).
[14] *Id.*, §570.202(b)–(f)(1979).
[15] Charles A. Kreiman, Assistant Director, Program Standards Branch, Entitlement Cities Division, Office of Block Grant Assistance, Department of Housing and Urban Development, telephone interview, Dec. 21, 1979 (hereafter cited as Kreiman Interview).
[16] 24 C.F.R. §570.204(a)(2)(1979).
[17] *Id.*, §570.20(b)(1979).
[18] "Listing of Battered Women's Shelters Receiving CDBG Funding," July 1979. (This document does not indicate an author or sponsoring department. It was provided by Madeline Gold,

ranged from $2,500 to $250,000 and totaled $3,441,060 of FY 80 money.[19] HUD, however, has no system for reporting the use of CDBG funds for battered women's programs.[20]

No legislative or regulatory barriers prevent the use of CDBG funds for shelters to meet the emergency and transitional housing needs of battered women. The barriers that do exist appear to be related to problems of priority-setting and communication among the HUD area offices, local community development agencies, and programs for battered women seeking CDBG funding.

In testimony before the House Subcommittee on Select Education, Richard Fleming concluded:

> We know including Battered Women's Shelters as a eligible activity in our regulations is not enough. . . .Groups organized to carry out action programs to aid battered women continue to have great difficulty in using Federal (including HUD) programs for which they are eligible. . . .We conducted a phone survey to over thirty shelters, and most of the respondents stressed the need for technical assistance to help them put together successful applications, how to comply with the regulations and where to secure funding. To meet this growing problem, the Office of Neighborhoods, Voluntary Associations and Consumer Protection plans to hold a National Consumer Forum on Domestic Violence. . . .The main purpose of this Forum will be to assure that every battered women's shelter in the country is made aware of HUD's funding programs, and is provided with timely information—in plain English—on how to apply for HUD monies at the local level.[21]

Respondents in the needs assessment pointed out that local community development officials may not consider the housing needs of battered women as a priority concern. However, even when local officials do request CDBG funding for meeting housing needs of battered women, Federal officials may not respond favorably. For example, one community participating in the small cities program, a competitive grant program (see appendix B), listed a shelter for battered women as its highest priority among several projects. The funding for the shelter was denied by the HUD area office although other projects were approved.[22]

Lower Income Housing Assistance Payments Programs

Section 8 of Title II of the Housing and Community Development Act of 1974 established the lower income housing assistance payments program,[23] (described in appendix B). Section 8 has two programs. Under the existing housing program, the eligible family locates housing of appropriate size and cost. If the unit meets HUD standards, the owner is paid the difference between the contract rent and what the family can afford (no more than 25 percent of their income). Under other programs (new construction, substantial rehabilitation, and moderate rehabilitation) the owner contracts with HUD, in advance of construction, to make a percentage of the units in the building available for lower income families in return for assured rent for these units.

Under the existing housing program, a would-be tenant who meets the income eligbility critiera (no more than 80 percent of the median income in the area) must receive a certificate of family participation.[24] Certificates are issued according to the "preference categories" established in the community.[25] In the new construction and substantial rehabilitation program, "any private person or entity, including a cooperative, or a PHA (public housing authority) having the legal right to lease or sublease newly constructed or substantitally rehabilitated dwelling units,"[26] may participate as an owner.

The primary utility of section 8 to a battered woman is for the second stage when she is establishing an independent residence. According to HUD's Women's Policy and Programs staff:

> Battered women's shelters can participate in the New Construction/Substantial Rehabilitation program as developers, by building or renovating a multifamily residence to be occupied by eligible families as second-stage or permanent housing.[27]

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program analyst, Women's Policy and Programs Staff, Office of the Assistant Secretary for Neighborhoods, Voluntary Associations and Consumer Protection, Department of Housing and Urban Development, in an interview Dec. 3, 1979, hereafter cited as Gold Interview). The figures have been updated based on information provided by letter by Msgr. Geno C. Baroni, Assistant Secretary for Neighborhoods, Voluntary Associations, and Consumer Protection, Department of Housing and Urban Development, Oct. 31, 1980.

[19] Ibid.

[20] Gold Interview.

[21] "HUD's Efforts to Deal with the Problems of Domestic Violence," testimony at the hearings on Domestic Violence of the House Subcommittee on Select Education, Committee on Education and Labor, July 11, 1979, Washington, D.C. (hereafter cited as Fleming Testimony).

[22] Gold Interview.

[23] Pub. L. No. 93-383, §201(a), 88 Stat. 633, amending 42 U.S.C. §1437f (1976).

[24] 24 C.F.R. §882.209(a)(1979).

[25] *Id.*

[26] 24 C.F.R. §882.209(a)(3); §882.204(b)(1)(i)(c)(1979).

If a battered woman meets the income eligibility criteria for section 8 and if existing housing certificates or other section 8 units are available in a community, this program can be an important resource for second-stage housing.

The major problem in using section 8 for battered women is the disparity between the demand for assistance and the assistance that is available. For the existing housing program, some PHAs have 3-year waiting lists.[28] Regulatory restrictions on the use of these funds for single persons (one person households) further limit the utility of this program for women without children. Only 15 percent of section 8 units may be used for single persons; however, before this group can be assisted, the law requires that priority be given to elderly, handicapped, and displaced individuals.[29] As a practical matter, unless the local PHA establishes a "preference category" for abused spouses, in most locales section 8 existing housing is not a viable resource for housing assistance to these victims.[30]

Only one shelter has succeeded in receiving section 8 funds to house battered women.[31] In other communities, shelter staff have been instrumental in getting the PHA to establish abused spouses as a preference category for section 8 certificates.[32]

Other Relevant Programs

AFDC Emergency Assistance

In the 21 States that provide for emergency assistance in the AFDC plan, recipients who meet the eligibility criteria (see appendix B), including victims of domestic violence, may receive assistance in securing family shelter.[33] This aid is available for no more than 30 days in any 12-month period, in response to an "emergency or unusual crisis situation."[34]

[27] U.S., Department of Housing and Urban Development, Women's Policy and Program Staff, "HUD Funding For Battered Women's Shelters," undated (hereafter cited as "HUD Funding for Shelters"), p. 3.

[28] Richard Finkleman, Housing Programs Officer, Section 8 Existing Housing Division, Office of Section 8 Existing Housing and Moderate Rehabilitation, Department of Housing and Urban Development, interview in Washington, D.C., Dec. 3, 1979 (hereafter cited as Finkleman Interview).

[29] 42 U.S.C.A. §1437a (2)(1978).

[30] *Id.*

[31] Finkleman Interview; Gold Interview; Fleming Testimony.

Bureau of Indian Affairs Social Welfare Programs

American Indian women who are abused might qualify for housing assistance under the family and community services program of BIA (described in appendix B). The services available under this program provide maximum flexibility to meet the needs of the eligible population in the States in which the program presently operates.[35] They may include foster care services for adults and children, which is a possible resource for meeting the housing needs of battered Indian women.

LEAA National Priority and Discretionary Grants Programs

One of the major initiatives supported under these programs in the Law Enforcement Assistance Administration is the family violence program. The primary focus of this demonstration program is on developing a more effective response by the justice system to domestic violence. Among the many services this program supports as part of the comprehensive services to victims of family violence is housing placement, including emergency shelters for battered women and their children.[36]

Department of Defense

The Armed Forces do not support any emergency or transitional housing programs. Military bases may have unused facilities such as barracks that are not now made available for shelters or other temporary housing for battered women but that might be.[37] One problem is that military families who live on base are generally provided housing by virtue of the military status of the husband. When separation occurs because of wife battering, the abused spouse may no longer have rights to military housing.

Title XX

This highly flexible social services program may include the provision of room and board for more

[33] Gold Interview.

[34] 45 C.F.R. §233.210 (1979).

[35] *Id.*

[35] 25 C.F.R. §20.20 (1979). See also program description of BIA social welfare programs appendix B.

[36] Law Enforcement Assistance Administration, Guide for Discretionary Grant Programs, M4500.1G chap. 1, par. 4(c)6, p. 22. See also the *Background Paper* for the Family Violence Program, Dec. 21, 1978, p. 1.

[37] William J. Sheehan, Director, Office of Economic Adjustment, Office of the Secretary of Defense, "EAC Helps Community Help Self," *Commanders Digest*, vol. 21, no. 8 (June 1, 1978).

than 6 consecutive months if it is an integral but subordinate part of another service.[38] Under this provision, housing could be made available to battered women who are receiving social services supported through Title XX.

Community Action Programs

During the conduct of this study, the Community Services Administration sponsored several demonstration projects related to spouse abuse. These projects included 24 shelters for battered women in addition to the shelters operated as part of the model family crisis intervention centers supported by CSA.[39]

Public Housing

Through the low-income housing assistance program (public housing), HUD funds local public housing authorities (PHAs) to provide "decent, safe and sanitary housing and related facilities for families of low income."[40] The PHA may provide this housing either by acquiring existing housing, constucting new facilities, or contracting with private developers to construct public housing. Low-income families, including single persons who are elderly, disabled, handicapped, displaced, or the remaining members of a tenant family, are eligible for assistance. Many battered women and their families might qualify for public housing assistance. It is also conceivable that some units in public housing facilities might be set aside as emergency housing for battered women.

Urban Development Action Grants

Severely distressed cities and urban counties with a good record of providing housing for low- and moderate-income persons may receive grants from HUD under this program. These funds must be used for economic development or neighborhood revitalization projects similar to those supported under community development block grants. These funds may also be used to build new housing.[41] Battered women in these communities might benefit from these programs either by the creation of additional units or through the support of shelters.

Urban Homesteading

Under this program, HUD-owned properties are transferred at low cost to individuals or families who meet locally established eligibility criteria and who wish to rehabilitate the buildings and live in them for a period of time. Homesteaders may also receive HUD loans for substantial rehabilitation.[42] Battered women might qualify for homeownership under this program in many communities.

Rural Rental Assistance Payments

This program, operated by the Farmer's Home Administration of the U.S. Department of Agriculture, provides rental assistance payments similar to those in the section 8 program. This assistance "may be used to reduce the rents paid by low-income senior citizens or families and domestic farm laborers and families whose rents exceed 25 percent of an adjusted annual income."[43] This program is of potential benefit to battered women in rural areas in seeking second-stage housing.

Disposal of Federal Surplus Real Property

The General Services Administration or HUD may dispose of surplus real property owned by the Federal Government for various purposes. These may include sale or lease of such property for "provision of housing for families or individuals of low- or moderate-income and for related public facilities. . . ."[44] This program might be of use to shelters or other organizations serving battered women in providing emergency, short-term, or, possibly, long-term housing for these women.

[38] 42 U.S.C. §1397(a)(7)(E).
[39] U.S., Community Services Administration, undated fact sheet surveying CSA programs for victims of domestic abuse.
[40] 1979 *Catalog of Federal Domestic Assistance* §14.146.
[41] *Id.*, §14.221.
[42] *Id.*, §14.222.
[43] *Id.*, §10.427.
[44] *Id.*, §39.002.

Chapter 3

Social Services

Assessment of Social Service Needs

Social services are defined in this report as those programs or activities designed to improve or develop individual social functioning and to solve or ameliorate problems that may result in diminished social functioning. Because social services address multiple social and economic factors, they must meet a wide range of individual problems and needs. Social services may, therefore, include crisis intervention, information and referral, counseling, training, employment counseling, housing assistance, legal services, and child welfare services. The broad focus and flexibility of these programs give them the potential to meet many of the priority needs of victims identified in this report.

This section focuses on the role of the social service agency in meeting victims' needs through direct services, advocacy, and coordination of services. The need for services to victims' children is also discussed. (The local department of social services usually provides public financial assistance also, which is discussed in a separate section.)

Direct Services, Advocacy, and Coordination of Services

A woman who wishes to leave an abusive situation is faced with immediate needs for the very basic essentials such as shelter, as well as long-range needs such as permanent housing or employment. She may have emotional and psychological needs that should be addressed. The respondents to the needs assessment identified low self-esteem, a sense of powerlessness, repressed anger, and depression as characteristics often shared by women who have experienced battering.

To respond to such needs, social services agencies may offer counseling, training, housing assistance, legal assistance, and child welfare services directly or buy needed services from other community agencies. Although services may be available, victims of spouse abuse may be unaware of their existence or reluctant or afraid to seek them. Two key services, information and referral and outreach, can be provided by social services agencies to help potential clients, including abused women, to learn about existing community services. Information and referral services are generally available to the public at no cost.

Several respondents expressed the need for greater coordination of services for victims so that a comprehensive service plan may be developed for each individual. Staff of social service agencies could serve as coordinators. Respondents also suggested that the battered woman needs an advocate who will provide continuing emotional support while also assisting her with the often complex application procedures required by service agencies. Social service staff might work also as advocates for abused women and their families.

Services to Children

Several respondents cited the need for various types of services for the children of victims. Many of the shelters indicated that they had some type of program for children, but the extent and nature of

the programs varied from organization to organization.

That children in spouse abuse situations suffer at least as much as other family members was stressed in both the telephone consultations and the literature. Elaine Hilberman and Kit Munson, writing in *Victimology,* state that the following portrait of the children emerges:

> Pre-school and young school children displayed somatic complaints, school phobias, enuresis and insomnia. The insomnia was often accompanied by intense fear, screaming and resistance to going to bed at night. . . .[1]
>
> Older children began to show differential behavior patterns which divided among sex lines. Aggressive, disruptive behavior, most usually fighting with siblings and schoolmates and temper tantrums when frustrated, was the most frequently reported cluster for male children. In contrast, female children continued to have an increasing array of somatic symptoms and were likely to become withdrawn, passive, clinging, and anxious, this pattern also occurring with a smaller number of males.[2]

Maria Roy's survey of 150 spouse abuse cases substantiates the negative effects on the children:

> About 45% of the assaults on the women were accompanied by similar physical assaults on at least one child in the household. The remaining 55% were situations in which children were not assaulted, but were witnesses to the attacks on their mothers.[3]

Concern was expressed by the respondents about the detrimental effects on children of repeatedly witnessing spouse abuse. In a New Jersey study of 97 domestic violence clients, women were asked whether the children had ever witnessed a violent incident during a 10-year period. About 57 percent of the women answered affirmatively.[4] According to a study by Morton Bard of the 36th precinct in New York City, children were present in 41 percent of the domestic disturbance cases.[5]

Children were often battered by both parents. J.J. Gayford's survey of 100 battered women in England found that 37 percent of the women admitted taking out their frustration on the children and 54 percent claimed the husband committed acts of violence against the children.[6]

> If the American family is a nightmare for spouses involved in domestic violence, it is even more so for their children. They suffer the consequences of their parents' battles simply because they exist.[7]

The serious consequences of growing up in an abusive family point to a need for therapeutic programs for children, including psychological and medical evaluations, counseling, peer support, and child advocacy services.

Evidence exists of a strong relationship between spouse abuse and child abuse. "Findings by a recent survey conducted by sociologists Richard Gelles and Murray Straus in conjunction with Susanne Steinmetz, indicated that the rate of child abuse is 129 percent higher in families where there is spouse abuse."[8] Lenore Walker states that "living in a violent family is the most insidious form of child abuse."[9] Respondents to the telephone survey suggested that in communities where consortiums on battered women are being established to coordinate services to victims, child protection teams should be represented.

Another suggestion was that training materials be developed for teachers and day care workers, dealing with the needs of abusive families and techniques of working with the children. Because the acceptability of using violence in family relationships is often perpetuated from one generation to another, it was suggested that different ways of raising children may need to be taught to victims of spouse abuse. Further research on the effects of spouse abuse on children was also cited as an area of need.

Once an abused woman decides to leave the home, she must spend time arranging for financial assistance, employment possibilities, and other services necessary for independent living. If she has young children, she may need day care for them while she is trying to restructure her life. Some

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[1] Elaine Hilberman and Kit Munson, "Sixty Battered Women," *Victimology: An International Journal,* vol. 2, nos. 3–4, (1977–78), p. 463.

[2] Ibid.

[3] Maria Roy, "A Current Survey of 150 Cases," *Battered Women: A Psychological Study of Domestic Violence* (New York: Van Nostrand Rheinhold, 1977), p. 33.

[4] State of New Jersey, Department of Human Services, Division of Youth and Family Services, *Physically Abused Women and Their Families: The Need for Community Services,* Program Development Guide (Trenton, N.J.: June 1, 1978), p. 41.

[5] Del Martin, *Battered Wives* (San Francisco: Glide Publications, 1976), p. 22.

[6] Ibid., p. 23.

[7] Ibid.

[8] *Legal Response: Child Advocacy and Protection,* National Legal Resource Center for Child Advocacy and Protection, American Bar Association, Young Lawyers Division, June–July 1979 issue, vol. 1, no. 2, p. 1.

[9] Ibid.

respondents noted that day care is often difficult to locate and that eligibility requirements restrict many women from obtaining it.

Selected Federal Programs Addressing Social Services Needs

Core Programs

Title XX of the Social Security Act

This act provides formula grants to the States to assist in providing social services to public assistance recipients and certain other low-income persons. The Federal funds are used to reimburse the States for 75 percent of the costs of providing social services, with the exception of family planning services, which are reimbursed at a 90 percent rate,[10] and day care, which, under the Child Welfare Act of 1980, is reimbursed at the 100 percent rate.[11]

Title XX gives the States significant flexibility to define the services to be provided to eligible recipients. A requirement of the Federal legislation is that the services provided must be directed at attainment of one or more of the following goals:[12]

1. Achieving or maintaining economic self-support to prevent, reduce, or eliminate dependency;
2. Achieving or maintaining self-sufficiency, including the reduction or prevention of dependency;
3. Preventing or remedying neglect, abuse, or exploitation of children and adults unable to protect their own interests, or preserving, rehabilitating, or reuniting families;
4. Preventing or reducing inappropriate institutional care by providing community-based care, home-based care, or other forms of less intensive care; or
5. Securing referral or admission for institutional care when other forms of care are not appropriate, or providing services to individuals in institutions.

These goals are consistent with social services needed by battered women. The first three goals, in particular, could readily serve as a basis for the States' development of preventive and rehabilitative services focused on the social and psychological aspects of spouse abuse. Examples of the types of services that could be developed include, but are not limited to, the following:

- Information and referral services;
- Outreach services;
- Crisis intervention services, including 24-hour hotlines providing information and referral services, and crisis counseling;
- Emergency shelter services;
- Therapeutic counseling services, including peer group support, and lay and professional therapy;
- Housing services to assist in obtaining or retaining adequate housing, including minor repairs; and
- Legal services to assist with the resolution of civil matters such as child support, child custody, divorce, and civil rights.

These and other Title XX services could be provided directly by the public social services agencies or by purchasing services through private agencies and organizations geared to the needs of victims.

Since economic dependency is a characteristic of many victims, the self-support and self-sufficiency goals of Title XX are also pertinent to the service needs of battered women. Economic independence services could include vocational counseling, job skills training, education for employment, and job placement.

Where adult victims with children have problems with parenting, or the children are otherwise at risk of either psychological or physical harm, Title XX services could be developed to assist in meeting these needs. Child-rearing education, household management services, and consumer education could all be of assistance. Additionally, services such as emergency and long-term day care services could be useful in giving the victim respite from her child care responsibilities, allowing her greater opportunity to make arrangements for job training, counseling, and other types of assistance.

Services might also go directly to the children. Counseling, drug abuse treatment, and other forms of professional therapy could be useful in overcoming the effects of witnessing violence in the home. Day care and recreational services would offer the children an opportunity to develop positive relationships with their peers.

[10] 42 U.S.C. §1397a(a)(1) (1976).
[11] Adoption Assistance and Child Welfare Act of 1980, Pub. L. No. 96-272, §202, 94 Stat. 500 (to be codified at 42 U.S.C. §1397a).
[12] 42 U.S.C. §1397 (1976).

Another important provision under Title XX is the availability of funds for training social services staff.[13] Grants can be used for inservice training programs for staff of the Title XX agencies, volunteers connected with the agency, and for certain staff of agencies providing Title XX services. These funds may also be used by educational institutions for training and retraining of personnel and for students who agree to work in the Title XX program. These grants offer an opportunity for training social services staff to work with domestic violence cases as well as for developing curricula for schools of social work on treatment of victims.

Eligibility for Title XX services is generally restricted to public assistance recipients and certain other low-income persons. A State may provide services without imposing a fee to recipients of aid to families with dependent children (AFDC), supplemental security income (SSI), and to persons with family incomes less than 80 percent of the median income for a family of four (adjusted for size).[14] Persons with a family income at or over 80 percent of the median for a family of four (adjusted for family size), but less than or equal to 115 percent, may be eligible for the receipt of Title XX services, but a fee must be charged for services provided.[15] Persons with an income greater than 115 percent of the median income for the same size family are ineligible to receive Title XX services, except for information and referral services, family planning services, or any service directed at preventing or remedying neglect, abuse, or exploitation, or unless a fee or other charge reasonably related to income is imposed on the individual for the provision of the service.[16] This income exception for protective services, of particular relevance to adult and child victims of violence, affords the States an opportunity to meet many of the service needs of *any* victim of spouse abuse.[17]

Most States, however, have not taken advantage of this opportunity. The access of adult victims to protective services has been limited by the States' interpretation of the phrase "unable to protect their own interests" as being solely applicable to elderly people or physically or mentally incapacitated persons. Such an interpretation excludes adult female victims of violence who are not elderly or do not meet a strict interpretation of physical or mental incapacity.[18]

States have identified the needs of child neglect and abuse victims as a priority area for Title XX services. For FY 1979, combined State and Federal expenditures for Title XX child protective services were about $301.3 million.[19]

A final barrier to battered women's use of Title XX services is the federally imposed ceiling of $2.9 billion on appropriations through FY 81. Since Title XX is a generic rather than a categorical social services program, the needs of various groups must be met out of the single grant to the State. Children, the elderly, the disabled, youth, and families all compete for a share of the funding. In this competition the older, established, organized constituencies are more likely to receive consideration from the State legislative and administrative agencies. Since all States were near or at their expenditure ceilings for Federal grants as of June 1980, newly identified social services needs must go unmet, be met through a reduction of funding in other service areas, or be met without Federal matching funds.[20]

Community Action Programs

Community action programs (CAPs) are authorized by the Economic Opportunity Act of 1964, as amended.[21] CAPs are community-based programs providing a range of services and activities meant to have a major effect on the problems of poverty. The primary purpose of a CAP is to mobilize public and private resources to help impoverished persons become fully self-sufficient.

The community action agency (CAA) is responsible for planning, implementing, and evaluating the CAP. CAAs are given wide discretion by the Community Services Administration (CSA), the Federal administrative agency, to develop and operate programs to assist participants to:

- Secure and retain meaningful employment;
- Attain an adequate education;

[13] 42 U.S.C.A. §1397a(a)(1) (Supp. 1979).
[14] 42 U.S.C. §1397a(a)(5)and (B)(i) (1976).
[15] *Id.*, §1397a(a)(6)(B)(i)(I).
[16] *Id.*, §1397a(a)(6)(A).
[17] *Id.*
[18] Interview with Michio Suzuki, Acting Director, Office of Program Coordination and Review, OHDS, DHHS, in Washington, D.C., Nov. 15, 1979. Mr. Suzuki was formerly Commissioner, Public Services Administration, DHHS, which administered Title XX.
[19] U.S., Department of Health, Education, and Welfare, *Technical Notes: Summaries and Characteristics of Title XX Social Services Plans for Fiscal Year 1978* (June 15, 1979), p. x.
[20] Telephone interview with Michio Suzuki, Nov. 22, 1979.
[21] 42 U.S.C. §§2781-82;2790-95 (1976).

- Use available income more effectively;
- Provide and maintain adequate housing and a suitable living environment;
- Undertake voluntary family planning;
- Obtain services for the prevention and treatment of substance abuse;
- Obtain emergency cash assistance to meet immediate and urgent needs, including the need for health services, nutritious food, housing, and employment-related assistance;
- Remove obstacles and solve personal and family problems that block the achievement of self-sufficiency;
- Achieve greater participation in community affairs; and
- Make more frequent and effective use of other programs serving the poor.[22]

The Community Services Administration may not establish national priorities for the use of CAP funds.[23]

CAPs could help meet the social services needs of low-income battered women, since the legislation allows for flexibility in programs. A CAA may operate a fairly comprehensive program for victims of violence, including emergency shelter, emergency cash assistance, advocacy services, assistance in finding permanent housing, peer group and professional counseling, employment training, legal counseling, etc.[24] (CAA programs must not, however, duplicate services that are already available in the community.) In fiscal year 1979, 24 spouse abuse programs encompassing emergency shelter and support services received funds through CAAs or through direct support from CSA, under its other grant programs.[25]

CSA also makes grants or contracts to provide technical assistance and training to develop and run CAPs.[26] In fiscal year 1979, training and technical assistance grants were provided for workshops for agencies serving victims of violence. One project grant in Pennsylvania was used to conduct eight training workshops in the area of spouse abuse program management and development.[27] Particular emphasis was given to measurement of the effectiveness of nontraditional methods of managing shelters for victims of violence. Another grant provided for planning, implementation, and evaluation of a comprehensive training program to upgrade the quality of services provided to battered women and children in Massachusetts.[28]

CSA is also authorized to make grants or contracts for testing or developing new approaches or methods that can overcome special problems of the poor. In fiscal year 1979, CSA funded several model family crisis intervention centers with adjunct women's shelters.[29]

Barriers to the use of CAP funds for helping low-income victims of violence are the CAAs' insufficient awareness of the need and willingness to provide the needed services, and, in instances where they are aware, lack of available funds.

Bureau of Indian Affairs (BIA) Social Welfare Programs

BIA social welfare programs are authorized by chapter 115 of the Snyder Act of 1921, as amended.[30] Child welfare assistance, family and community services, general assistance, and miscellaneous assistance[31] are provided to American Indians living on or near reservations, where such help is not already available through State, local, or other welfare agencies.

BIA's family and community services program appears to have as great a flexibility as Title XX of the Social Security Act to provide a variety of services to meet needs of Indian spouse abuse victims. Although the program regulations do not specify spouse abuse as a category for service provision, authorization for providing services to victims and their families appears to exist in the following service definitions:

a. Family and individual counseling to assist in solving problems related to family functioning, housekeeping practices, care and supervision of children, interpersonal relationships, economic opportunity, money management, and problems related to illness, physical or mental handicaps, drug abuse, alcoholism, and violation of the law;
b. Child and adult protective services; and

[22] *Id.*, §2808(a).
[23] *Id.*, §2791(e).
[24] U.S., Community Services Administration, undated fact sheet surveying CSA programs for victims of domestic abuse (hereafter cited as CSA fact sheet). See also 42 U.S.C. §2808(a) (1976 and Supp. 1978).
[25] CSA fact sheet.
[26] 42 U.S.C. §2823 (1976).
[27] CSA fact sheet.
[28] Ibid.
[29] Ibid.
[30] 25 U.S.C. §13 (1976).
[31] 25 C.F.R. §20.2 (1979).

c. Community services including evaluation and treatment of conditions that are within the competence of social services, and the maintenance of liaison relationships with other community agencies for purposes of identifying and facilitating the utilization of other existing services.[32]

Within the framework of these service definitions, a variety of programs could be developed. For example, support services for emergency shelters serving victims of spouse abuse could be provided, along with counseling services. Homemaker and day care services would help the victim provide adequate child care. Where other specific services, such as medical assistance are not provided, referrals to these services could be made.

Therefore, the family and community services program is predominantly focused on services for children and the elderly. Adult protective services are interpreted as being predominantly for aged and disabled persons. BIA's on-reservation services are required to be consistent with tribal customs, codes, and laws.[33] Where Indian tribal governments have not identified spouse abuse as a problem area, services are not likely to be provided to victims.

Other Relevant Programs

Child Abuse and Neglect Prevention and Treatment

The Child Abuse Prevention and Treatment Act[34] authorizes the National Center on Child Abuse and Neglect to provide training and technical assistance to programs and persons serving abused and neglected children and their families. The center may also run demonstration projects to develop multidisciplinary approaches to identification, prevention, and treatment of child abuse and neglect; maintain regional centers to collect and disseminate information on child abuse; make grants to the States for services to abused and neglected children and their families; and do research on the causes, prevention, and treatment of child abuse and neglect. The act is relevant to the needs of battered wives because wife battering and child abuse are often concurrent and because of the adverse effect that violence may have on the psychological development of children. Research and demonstration projects could contribute to a greater understanding of any linkage between child abuse and wife beating and to the development of training and services for all members of the family. The self-help groups supported by the act could provide peer group support if adult female child abusers are themselves abused persons. Information programs could be run to make the public more aware of spouse abuse as a social problem and what could be done to prevent it. The Federal funding for the Child Abuse Prevention and Treatment Act was $22,928,000 for fiscal year 1980. The grants provided are generally time-limited, with no provisions for ongoing funding for successful programs and services.[35]

DHHS Native American Programs

Title VIII of the Community Services Act of 1974,[36] as amended, authorizes the Department of Health and Human Services to make grants and enter into contracts with the governing bodies of Indian tribes, Alaskan Native villages, regional corporations, and other public and nonprofit agencies to promote the goal of economic and social self-sufficiency for American Indians, Alaskan Natives, and Native Hawaiians. Grants may be used for purposes such as increasing the ability of Indian tribal governments to provide services now provided by non-Indian-controlled organizations, implementing programs to promote individual and family self-sufficiency, operating urban centers for Indian people living offreservation, and developing self-help and community economic development programs. The Native American programs could be used for social service programs run by persons who have an understanding of the social and cultural needs of Native American domestic violence victims. Programs of services could be developed either on or offreservation.

The only apparent barriers to using the HHS Native American programs for domestic violence victims are the degree of priority put on requests for grants and the initiative of HHS staff in seeking proposals related to the provision of such services. Spouse abuse programming has not been established as a priority by the HHS Administration for Native Americans.

[32] 25 C.F.R. §20.24(b)(1), (2), (6) (1979).
[33] *Id.*, §20.2[illegible]
[34] 42 U.S.C. §§5101-06 (1976).
[35] 42 U.S.C.A. §§5101-15 (1977 and Supp. 1980).
[36] *Id.*, §2991 (1976).

Community Development Block Grant Program

The provisions of the community development block grant (CDBG) program (see appendix B) allows cities to provide otherwise unavailable services for the employment, crime prevention, child care, health, drug abuse, education, welfare, or recreation needs of residents in areas affected by community development activities.[37] This provision has the potential of helping to meet some of the social services needs of battered wives, such as the need for day care services or education services to help improve employability. For CDBG funds to be made available for these purposes, the area in which services are to be provided must be involved in community development activities, similar services must be unavailable, and a sufficient need for services must exist. The services provision of the CDBG program would be particularly useful if housing for abused spouses were being provided with CDBG funds.

Comprehensive Employment and Training Act (CETA)—Special Programs and Activities for the Disadvantaged

Under Title III of CETA (see appendix B), project grants may be made to State and local governments, Federal agencies, and private nonprofit agencies to provide job training and other employment-related services to groups with particular disadvantages in the labor market. Identified disadvantaged groups include displaced homemakers, single persons, and women. Such services could assist adult female victims in meeting their need for economic independence. Eligibility for the program is generally limited to economically disadvantaged persons, with further targeting by sex, age, race, or other demographic factors.

Law Enforcement Assistance Administration (LEAA) National Priority and Discretionary Grants Program

A main initiative of LEAA's national priority and discretionary grants program (see appendix B) is the family violence program. Among its activities, the program has provided funding for 20 model programs of services for battered wives. This program provides a comprehensive range of services, including emergency housing, counseling, advocacy, vocational counseling, and legal services.[38] The Community Services Administration has joined with LEAA in funding these demonstration projects.

Office of Juvenile Justice and Delinquency Prevention—Special Emphasis Prevention and Treatment Programs, Formula Grant Programs

The special emphasis programs of the Office of Juvenile Justice and Delinquency Prevention within LEAA are discretionary programs and conceivably could focus on the problems of youth living in violent homes. Additionally, shelters might apply for funding through the State formula grants to establish programs for the children of battered women who are at the shelters.

[37] *Id.*, §5305(a)(8)(A) (1976).

[38] U.S., Department of Justice, Law Enforcement Assistance Administration, *Guideline Manual: Guide for Discretionary Grant Programs*, M 4500.1G (Sept. 30, 1978), pp. 19–26.

Chapter 4

Financial Assistance

Assessment of Financial Assistance Needs

The economic dependence of the female victim has been identified in the needs assessment as one of the primary reasons that she remains involved in an abusive relationship. Many women who have worked only in their own household lack the marketable skills necessary for employment. Without some type of financial security, many women, particularly those with children, have no option but to remain in their homes despite continuing abuse.

A number of factors contribute to the economic dependence that locks women into abusive situations. These include a lack of available employment opportunities, a lack of available public emergency financial assistance, the inadequacy of financial assistance payments, the complexities of the financial assistance application processes, and restrictive eligibility criteria for public financial assistance.

Emergency Assistance

When a woman decides to leave home to avoid further battering, she is faced with the need for immediate financial assistance. Women who leave home to avoid further battering often do so in a crisis situation and do not have time to plan and prepare adequately for the consequences of such an action. They may have little or no cash on hand and may not have access to the family income once they have left. Women in this situation need emergency financial assistance until other arrangements can be made to meet their ongoing financial needs or until they reconcile with their spouses. However, respondents and experts indicated that emergency assistance was often not available to battered women. Del Martin observed that, "Rules, regulations, and procedures are rigid and do not allow social workers any flexibility in responding to crisis."[1] She summarized the woman's plight as follows:

> The suggestion that a woman can escape a brutal husband by moving to another county and applying for aid once again presupposes that she has some money for bus fare or a car with plenty of fuel. She must arrive at the welfare office before five on a weekday. She must apply for emergency food and accommodations to see her through until her first check arrives. But suppose she did not bring the legal documents required (birth certificates and so forth). Suppose she finds herself at the bottom of a long waiting list. What then? All across the country, applicants for welfare often wait as long as ten days for the first interview to determine eligibility and, if they qualify, another two weeks or so for the first check. The idea of a woman dropping in on the welfare office after she has left home simply does not hold up.[2]

Respondents, too, cited long waiting periods for some financial aid programs as barriers that prohibit effective service to battered wives. Financial assistance staff at income maintenance agencies need to understand the emergency needs of the woman when she decides to leave the the abusive home. According to Del Martin, "Contingency funds should be made available for unusual emergencies,

[1] Del Martin, *Battered Wives*, (San Francisco: Glide Publications, 1976), p. 132.

[2] Ibid., p. 131.

and some provision should be made for crisis situations that happen at night or on weekends when offices are closed."[3]

Ongoing Financial Assistance

The financial needs of the victim, in her efforts to support herself and her children, go far beyond the crisis period. Women who choose to leave a violent situation need financial support to set up and maintain themselves and their children independent of the husband's income. The female victim in this situation cannot depend on support from the male provider. Jennifer Fleming points out:

> The assumption that fathers provide support following marital dissolution, particularly in cases where the father chooses to be recalcitrant, is largely unfounded. It is estimated that over 5.8 million nonwelfare families in the United States have problems of nonsupport in addition to the 2.9 million families on assistance. . . .The abused wife or former wife may also be subject to further abuse if she attempts to enforce support.[4]

If the victim is not able to enter the labor force due to lack of skills, job opportunities, or day care for her children, she must depend on public financial assistance programs, such as aid to families with dependent children (AFDC). However, victims may be confronted with numerous obstacles in trying to obtain public assistance. For example, according to a report prepared by the Connecticut Advisory Committee to the U.S. Commission on Civil Rights, in some areas of that State a woman must file a formal legal separation if her husband has income in order to obtain public assistance.[5]

Many battered women are unfamiliar with the public welfare system and the process of applying for public assistance. Several shelter directors who responded to our telephone consultation indicated that their organizations provide social service advocacy, described as working with specific social service agencies to eliminate some of the barriers in the financial assistance application process.

Coupled with unfamiliarity of many abused women with the public welfare system is the stigma of public assistance. Fleming summarizes this point:

> The prospect of poverty interacts with fear of social stigmatization. Stigma accrues not only to poverty in our society, but to the individual judged to be illegitimately dependent on others for support. . . .The image persists, along with the social devalued stereotype of the "welfare freeloader" to serve as a powerful deterrent to some women who are reluctant to accept even the economic aid to which they are entitled.[6]

According to respondents, one major obstacle to obtaining public assistance is that a woman may be determined to be ineligible because the husband's income is judged to be a family income resource. Del Martin states: "[In some States] As long as a woman has a home to go to and a husband to support her and the children, no matter what the circumstances, she cannot qualify for public assistance. Technically she is not destitute or homeless, the only conditions that qualify an applicant for public aid."[7]

Another problem in applying for public assistance is that the battered woman is required to disclose her residence. She may want to keep her new address confidential for fear of her husband finding her; if she is in a shelter, she may be required to maintain this confidentiality for the protection of other victims. According to a program development guide issued by the State of New Jersey Division of Youth and Family Services, "It is usually required that the husband be contacted when aid is given, and consequently the woman's county of residence is disclosed."[8] The guide also states that, "According to the provisions of the Social Security Act, a welfare board can honor a request from a woman to forego seeking support from her husband if the seeking of such support would be harmful to the interests, or the physical well-being, of the family or children."[9]

Respondents pointed out that welfare workers (as well as staff of other public service agencies) are often not sensitive to the special problems faced by battered women. Public welfare staff, especially intake workers, need training on domestic violence issues in order that they use what latitude they have in interpreting the regulations on eligibility to meet the needs for income by battered wives. The

[3] Ibid., p. 132.
[4] Jennifer Baker Fleming, *Stopping Wife Abuse*, (Garden City, N.Y.: Anchor Press/Doubleday, 1979), p. 90.
[5] Connecticut Advisory Committee to the U.S. Commission on Civil Rights, *Battered Women in Hartford, Connecticut* (April 1979), p. 22.
[6] Fleming, *Stopping Wife Abuse*, pp. 90-91
[7] Martin, *Battered Wives*, p. 131.
[8] State of New Jersey, Department of Human Services, Division of Youth and Family Services, *Physically Abused Women and Their Families: The Need for Community Services*, Program Development Guide (Trenton, N.J.: June 1, 1978), p. 41.
[9] Ibid.

importance of the role of the intake worker is illustrated in an example given by Del Martin:

> In 1975, the California Senate Subcommittee on Nutrition and Human Needs held hearings on marital violence. Sue Millhollon, of the Salvation Army's Social Service Bureau, testified at the hearings as to the frustration her agency experienced in helping fleeing women deal with the public social services. In one case she cited, a battered woman and her children were told that the husband's income made the family ineligible for welfare. The wife and her children had been subject to continued beatings, and were trying to make a break from this unbearable situation though they had no money of their own. But the intake worker was not moved. The woman was classified ineligible and forced to go back to her violent husband.[10]

Selected Federal Programs Addressing Financial Assistance Needs

Core Program: Aid to Families with Dependent Children (AFDC)

The aid to families with dependent children (AFDC) program is authorized by Title IV-A of the Social Security Act. AFDC is the primary potential source of federally supported cash assistance for battered women. (See appendix B.)

Title IV-A makes formula grants to the States to assist in providing cash payments to encourage the care of dependent children in their own homes or in the homes of relatives. The cash payments are made to assist in meeting the child's basic needs for food, clothing, and shelter. The basic needs of the adult caretaker are taken into account only as they affect ability to support or care for the child.

To be eligible for AFDC payments the family must include a child, residing in the home, who is dependent, that is, deprived of parental support or care by reason of the death, continued absence from the home, or mental or physical incapacity of a parent, or in some States, unemployment of a parent. Additional AFDC eligibility requirements are that the family must have income and resources less than an amount determined by the State, and adult applicants/recipients must comply with requirements for work and training and the collection of child support. (See appendix B.)

The Federal AFDC legislation and its implementing regulations serve as a policy framework for the operation of the program at the State and local levels of government. The States are responsible for determining the standard of need (the basic cost requirements for food, shelter, and clothing) and the actual amount of cash benefit provided to recipients. States are reimbursed at a rate between 50 and 65 percent of the costs of the assistance provided.[11]

The Federal AFDC guidelines provide a means for meeting both the emergency and ongoing financial assistance needs of a well-defined subcategory of adult female victims of domestic violence. The characteristics of this subcategory are as follows:

1. They are the mothers of children under the age of 18, and in some States, age 21, if the child is attending school full-time, or the application is for emergency assistance for States that have opted for this program;
2. They have left the abusive situation, taking the children with them, or the abusive mate has left the family home;
3. They do not have income or resources available for their immediate use beyond the limits set for AFDC eligiblity; and
4. They have otherwise met all the requirments for AFDC eligibility, having registered for employment or job training (unless they are exempt) and having assigned rights for the collection of child support payments to the welfare department.

Adult female victims of domestic violence have fundamental AFDC eligibility because of the child(ren)'s dependency, due to "the continued absence of a parent from the home."[12] Federal regulations do not require a specific period of absence of a parent to meet this requirement.[13] The term "home" is interpreted as the place where the caretaker parent resides with the child.[14] Therefore, if the mother has moved from the family home into an emergency shelter along with her child(ren), then the shelter is considered to be the home.[15]

According to Federal regulations, only the income and resources that are "actually available for

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[10] Martin, *Battered Wives*, pp. 129-30.

[11] *Characteristics of State Plans for Aid to Families with Dependent Children* (1978)., pp. 236-37(hereafter cited as *State Plan Characteristics).*

[12] 42 U.S.C. §606(a)(1976).

[13] 45 C.F.R. §233.90(c)(1)(iii)(1979).

[14] 45 C.F.R. §233.90(c)(i)(v)(B)(1979).

[15] C.B. Wooldridge, AFDC specialist, Administration for Family Services, Social Security Administration, telephone interview in Washington, D.C., Jan. 18, 1980(hereafter cited as Wooldridge Interview).

current use on a regular basis" may be considered in determining AFDC financial eligibility.[16] This requirement means that the income and resources of the absent parent are not to be counted in determining AFDC eligibility if he does not reside in the same home as the adult female victim of domestic violence and her children and is, in fact, not contributing. Income and resources that are joint property may not be counted, when they are not actually available to the applicant or recipient.

Although the father's income and resources are not counted in determining eligibility, the Federal legislation does require as a condition for the adult female's eligibility that the caretaker parent must cooperate with the State in obtaining child support payments from the child's father and, further, that she assign the rights to the collection of such payments to the State welfare department.[17] Any payments collected by the State are used to offset or supplement the AFDC benefits provided to the parent and children.[18]

Federal regulations, however, specify that a woman may refuse to cooperate in the collection of child support payments with "good cause" when such efforts are deemed not to be in the best interests of the child.[19] Among the "good cause" reasons considered not to be in the best interests of the child are reasonable anticipation that efforts to collect child support may result in either physical or emotional harm to either the woman or the children.[20] A woman who has left a relationship because of physical or emotional abuse most likely will find it easy to establish "good cause" for refusing to cooperate in the collection of child support, especially if there are court, law enforcement, social service, or other types of records that document the abuse.[21] The refusal of the caretaker parent to cooperate in the collection of child support without good cause cannot be used by the State to deny benefits to the children.[22] Under such circumstances the State may only deduct from the assistance check that portion attributable to the parent's needs.[23]

If the State in which the victim resides participates in the emergency assistance program, Federal regulations permit the application of more liberal income eligibility requirements than would be used to determine eligibility for ongoing AFDC assistance.[24] The forms of emergency assistance that may be made available by the State include information and referral services, counseling services, assistance in securing family shelter, food services, legal services, medical services, cash loans, cash assistance grants, and any other services that meet needs attributable to the emergency or unsual circumstances.[25]

Although the Federal AFDC legislation and regulations provide a policy framework for meeting the financial assistance needs of domestic violence victims, the ultimate determinants of whether such assistance is actually available are the policies and procedures of the individual States. States have enough leeway within the Federal guidelines to make access to AFDC payment easier or harder than the Federal guidelines state. In fact, the major barriers to victims of violence receiving financial assistance are the specific requirements of the State AFDC plans.[26] Some States place a low ceiling on the assets an AFDC applicant may have. For example, the ceiling on personal and real property (other than the home) is $800 per family in Georgia; $500 for an adult and one child in Nevada, with $150 allowed for each additional child; and in Oklahoma $550 is allowed for an adult with one child, and $50 for each additional child.[27] In other instances a lien may be placed against real property assets as a condition for eligiblity. These specific requirements of some State AFDC plans exclude persons from eligibility, or at a minimum discourage application for assistance.

At their option, States may expand the coverage of the basic AFDC program by providing emergency assistance (EA).[28] As of September 1979, nine

[16] 45 C.F.R. §233.90(a)(1)(1979).
[17] 42 U.S.C. §602(a)(26)(B)(1976).
[18] *Id.*, §602(a)(28).
[19] 45 C.F.R. §232.40(a)(1979).
[20] *Id.*, §232.42(a)(1)(1979).
[21] *Id.*, §232.43.
[22] *Id.*, §232.12(d).
[23] *Id.*
[24] *Id.*, §233.120(a)(1).
[25] *Id.*, §233.120(b)(2).
[26] See the eligibility requirements section for each State in *State Plan Characteristics.*
[27] U.S., Department of Health, Education, and Welfare, Social Security Administration, *Compilation Based on Characteristics of State Plans for Aid to Families with Dependent Children: Need, Eligbility and Administration in Effect April 1, 1978,* (SSA 79 08005, pp. 37–39 (hereafter cited as *State Plan Compilation).*
[28] 42 U.S.C. §§603(a)(5),606(e)(1976).

States included some form of AFDC-EA in their cash assistance programs.[29] However, even these nine States have not adopted regulations that take full advantage of the opportunities afforded by the Federal regulations to aid battered women.[30] For example, in Delaware eligibility is limited to current AFDC recipients, and in Virginia to specific emergencies caused by natural disasters.[31] Ohio, however, is the only State that specifically includes victims of violent crimes as an eligible category.[32]

The needs assessment telephone consultations and the literature review indicate that in some instances States are imposing requirements that are clearly in opposition to the Federal legislation and regulations. For example, the income and resources of the father were sometimes counted in determining the AFDC eligibility of adult domestic violence victims and their children.[33] This practice would exclude potential recipients because of excess income or resources that are not available to them. Federal regulations, however, specify that only income which is available on a regular basis can be considered. Another factor reported as impeding applications for assistance was the requirement for cooperation in the collection of child support because contact with the father sometimes resulted in his learning where the mother had taken refuge. The Federal regulations, however, clearly modify the child support reporting requirements if there is a danger of physical or emotional abuse of the children or mother.

A woman's AFDC payment may be reduced if she and her children are residing in a shelter that receives other Federal monies. While AFDC regulations do not require that the cash benefit be reduced,[34] a State does have the option to reduce the amount of the payment in this situation, depending on the State's in-kind income policy.[35]

Other Relevant Programs

Two additional individual entitlement programs, food stamps and medicaid, provide aid for two major costs, food and medical care, that a victim striving for financial independence may incur.

[29] U.S., Department of Health, Education, and Welfare, *Public Assistance Statistics* (March 1979), p. 15.
[30] *State Plan Characteristics*, pp. 28, 32, 36, 72, 88, 92, 96, 102, 114, 118, 129, 138, 162, 166, 205, 213, 221.
[31] *State Plan Compilation*, pp. 74–75.
[32] Ibid.
[33] Martin, *Battered Wives*, p. 130.
[34] Wooldridge Interview.

Food Stamps

The food stamp program, administered by the State or county welfare department, is authorized by the Food Stamp Act of 1964, as amended.[36] Eligibility for receipt of food stamps is based on household income, and able-bodied adults are required to register for jobs or job training, unless they have responsibility for the care of dependent children or are otherwise exempted from this requirement.[37] The food stamp program provides coupons that may be used at retail food stores to buy food. Persons with the financial ability to pay for the basic allotment of coupons receive a bonus in addition to the amount purchased, allowing them to stretch their food dollar. Those unable to purchase food coupons receive an allotment without charge.

Persons residing in institutions such as emergency shelters are generally ineligible to receive food stamps if the shelter provides all their meals as part of the shelter's normal services.[38] Exceptions to this requirement are State-approved drug and alcohol treatment programs and programs providing meals for the elderly.[39]

Battered women residing in shelters may be eligible for the receipt of food stamps if they furnish their own meals, or receive fewer than half of their meals from the shelters, or do not receive their meals as part of the shelter's normal services.[40] Battered women who have established independent living arrangments may qualify for the receipt of food stamps on their available income and resources.

Medicaid

The medicaid program is authorized by Title XIX of the Social Security Act.[41] The program provides grants to the States to assist in providing medical services to public assistance recipients and, in some instances, other needy persons. Services provided by medicaid include in- and out-patient hospital services, other laboratory and X-ray services, skilled nursing home services for persons who are over 21, home health care services, family planning services, physician's services, and early periodic screening,

[35] Ibid.
[36] 7 U.S.C.A. §§2011–2027 (Supp. 1980).
[37] *Id.*, §2014.
[38] 7 C.F.R. §273.1(e)(1979).
[39] *Id.*
[40] 44 Fed. Reg. 248, 76380 (Dec. 26, 1979).
[41] 42 U.S.C.A. §§1396–1396k (1974 and Supp. 1979).

diagnosis, and treatment (EPSDT) for persons under 21.[42]

The medicaid program provides a means of meeting the health care needs of victims of domestic violence who are AFDC recipients or who are otherwise qualified. Medical needs may be met under the Medicaid program both on emergency and long-term bases.

[42] 42 U.S.C. §1396d(a) 1-17(1976).

Chapter 5

Legal Services

Assessment of Legal Needs

A battered woman's need for safety and protection may involve both civil and criminal justice systems. The legal remedies that exist, however, are not clearly defined, readily available, or consistently enforced.

When a woman needs immediate protection from physical abuse by her spouse, she may first seek help from the local police. Their response may range from an attempt to cool down the situation to the arrest of the abuser. If the woman presses charges, other criminal justice agencies become involved in the case. The prosecutor's office determines if there is sufficient evidence to bring the case to trial. If the case goes to court, the judge plays a key role because of his or her authority to sentence the abuser. If the abuser is convicted the department of probation and parole may become involved.

Rather than go through criminal proceedings, the battered woman may try to obtain the needed help and protection through the civil justice system. As a short-term remedy, she may seek an order of protection from the court. As a long-range solution, she may initiate divorce proceedings.

Civil and criminal justice systems have numerous problems in providing services and some of the problems affect abused women.

The need for an improved response from local law enforcement officers was cited by respondents and substantiated in the literature review. Because they are normally the first to intervene at the point of crisis, the police response is critical. The police can arrest the abuser and initiate criminal proceedings. In some jurisdictions, they are also responsible for enforcing an order of protection.

Respondents suggested that substantial improvement is required in the criminal and civil remedies to provide ongoing protection to the victim. Clarification regarding procedures for arrest, prosecution, diversion from the justice system, and sentencing in abuse cases are among the improvements needed. Improvements in civil remedies would include simplification of procedures for obtaining an order of protection, clarification of jurisdictional responsibilities for enforcing the order, and simplification of procedures for obtaining a separation, divorce, alimony support, and incurring damages. The need to train all justice personnel who have the responsibility for assisting the victim in obtaining legal remedies and for enforcing them once obtained was stressed by respondents.

Additionally, because of the complexities of the civil and criminal justice systems, a need for advocacy was cited to assure that the victim understands all the options available to her and that she receives the legal assistance that she needs. On a broader level, advocacy efforts are needed that will result in the development of model wife abuse statutes as well as improvements in existing criminal and civil statutes.

The Criminal Justice System

The police are often the first outside authority called in spouse abuse cases. Because in most areas they have a 24-hour response capability, they can

meet the victim's need for "immediate, lifesaving protection."[1] The literature, however, suggests that in spite of this capability to prevent further violence, police intervention has often failed to interrupt the "spiral of violence."[2] Several studies indicate that in many spouse murder cases police had intervened previous to the final fatal attack, frequently on more than one occasion.[3] Reasons cited in the literature for inadequate police response include the low-priority status given domestic disturbance cases, police policies and attitudes regarding involvement in intrafamily situations, "the risk of liability for false arrest," the physical dangers posed by intervention, police training that often reinforces a nonarrest policy, and complicated requirements for making an arrest.

According to Darrel W. Stephens, assistant chief of police in Lawrence, Kansas, one of the most frequently called upon services the police provide is intervention in interpersonal conflict situations."[4] He goes on to say that "intervention in disputes between husbands and wives are by far the most dangerous for participants and the police."[5] The literature cites statistics on the high incidence of police injury or death in domestic disturbance calls.[6] According to Stephens, although statistics suggest that spouse abuse is a serious problem, the police have not traditionally dealt with it as such.[7]

Domestic disturbance calls may receive low-priority status or may be screened out by some police departments. According to Fleming, this policy is designed to eliminate calls that are least important thus reserving police response for more critical cases. Cases are ranked accordingly and frequently family disputes are given low priority.[8] Although a ranking system may be necessary when police resources are limited, increased understanding of the needs of victims and more effective screening criteria for spouse abuse cases are needed.

The low priority given to family disputes is based on the assumption that family problems are often "non-criminal 'disputes' or 'disturbances' essentially verbal in nature, not serious, and causing no one injury."[9] Stephens suggests that "police argue that they do not have the time to deal with family disputes when they should be addressing the more serious crime problems."[10]

In some localities family dispute calls are screened out completely and there is no official documentation showing the frequency with which police receive calls from the same families.[11] When police do respond to domestic disturbance calls, due to the low-priority status, the response is slow and often "the police do not arrive in time to witness or stop an assault."[12]

Despite the seriousness of the offense committed, during a domestic dispute police often do not arrest the perpetrator, but use several methods to "cool down" the situation. Traditionally, in domestic disturbance cases police actions are designed to mediate, resolve conflict, and protect the officer involved.[13] The no-arrest approach is stated policy in some police training curricula. For example, the training manual used at the police academy in Michigan instructs police answering domestic disturbance calls to "avoid arrest if possible"; "state your only interest is to prevent breach of the peace"; and "recommend a postponement."[14]

Marjorie Fields points out that some training publications stress that arrest should be the last resort even when responding to violent family disputes. Arrests are presented as "counterproductive." Fields suggests that the policy of nonarrest is based on an assumption that family disputes to which the police are called are not violent and will not result in injury to family members.[15]

The International Association of Chiefs of Police Training Key stresses the need to distinguish be-

[1] Marjory D. Fields, "Wife Beating: Government Intervention Policies and Practices," in *Battered Women: Issues of Public Policy* (consultation sponsored by the U.S. Commission on Civil Rights, Washington, D.C., Jan. 30–31, 1978), p. 229 (hereafter cited as Fields, "Government Intervention").

[2] Jennifer Baker Fleming, *Stopping Wife Abuse* (Garden City, N.Y.: Anchor Press/Doubleday, 1979), p. 171.

[3] Darrel W. Stephens, "Domestic Assault: The Police Response," in *Battered Women: A Psychosocial Study of Domestic Violence*, ed. Maria Roy (New York: Van Nostrand Rheinhold, 1977), p. 168.

[4] Ibid., p. 168.

[5] Ibid.

[6] Fields, "Government Intervention," p. 231. Stephens "Domestic Assault," p. 164.

[7] Ibid.

[8] Fleming, *Stopping Wife Abuse*, p. 171.

[9] Fields, "Government Intervention," p. 229.

[10] Stephens, "Domestic Assault," p. 164.

[11] Fleming, *Stopping Wife Abuse*, pp. 170–74. Terry L. Fromson, "The Case for Legal Remedies for Abused Women," 6 *NYU Rev. L. L. and Soc. Change*, pp. 135–74 (1977) at 144.

[12] Fleming, *Stopping Wife Abuse*, p. 170.

[13] Stephens, "Domestic Assault," p. 165–66.

[14] Del Martin, *Battered Wives* (San Francisco: Glide Publications, 1976), p. 93.

[15] Fields, "Government Intervention," p. 232.

tween family disturbances and wife abuse. The guide states that police response to a family dispute where no physical violence has occurred should be different from the police response where wife beating has already occurred. In the former, intervention by the police should be directed toward mediation so the conflicts can be resolved, thereby making an arrest unnecessary. Once, however, a physical assault has occurred, a crime has been committed and must be investigated in the same way a similar crime is investigated when it occurs between two strangers.[16]

The very relationship between the victim and the abuser in spouse abuse cases often complicates the police response and affects the decision to arrest. According to Morton Bard:

> Police arrest practices are usually different for assault cases occurring within families than those between strangers. In the former, the aggrieved may be tied economically and socially to the accused. What is more, it is very difficult to engage in routine family life activities while the emotional and financial strains associated with adversary court proceedings are pending.[17]

The situation is further complicated for the police because most States have no specific wife abuse statutes. Rather, spouse abuse falls under several different misdemeanor and felony charges ranging from simple assault and battery, aggravated assault, assault with intent to maim or disfigure, to assault with intent to murder.[18] Furthermore, the complicated and varying prerequisites for misdemeanor and felony arrests, along with regulations regarding arrest without warrants, place major responsibility for deciding when to arrest with the police officer. According to Fleming, "Their decision to arrest or not to arrest the man depends primarily on their interpretation of the seriousness of the crime and the likelihood that it will continue if they do not arrest."[19] Although conditions for arrest vary from locality to locality, in general, in misdemeanor cases, police cannot arrest without a warrant, unless they have witnessed the offense. In spouse abuse cases it is unlikely that the police would witness the offense since they are usually called after it has occurred. For a warrant to be issued, the victim must file a complaint with the prosecuting attorney. In felony cases, in many localities, an officer can arrest without having witnessed the offense when there is a reasonable belief that a felony has been committed and that the person identified by the victim or witnesses has committed the crime."[20] Del Martin suggests, however, that "this provision, being the most subjective and also the easiest to ignore is rarely invoked in wife abuse cases."[21]

Fromson points out that the decison to arrest may be based upon factors "more compelling than simply a concern that a crime has been committed or that someone has been harmed." She suggests that in domestic violence cases more arrests occur when the peace of the neighborhood has been disrupted, a deadly weapon has been used, or when the assault is so serious that the police have no alternative. Even then the charges filed may not reflect the severity of the crime committed.[22]

An option available to the woman who wants her husband or partner taken into custody even if the police do not arrest him is the citizen's arrest. This option varies from State to State as does the amount of relief it actually provides. According to Fromson:

> The police often fail to inform women of their right to make such an arrest and thus effectively deny it to the woman who is not aware of this alternative. If she is aware of it, the police may still discourage her from using it and may refuse the help necessary to take the man into custody and complete the arrest. Procedures for civilian arrests may themselves incorporate the non-arrest policy by unreasonable requirements such as requiring the victim to take physical custody of her attacker and deliver him to the police. Since the woman has most likely called the police for help because she is unable to handle the man alone, she cannot meet such requirements and is effectively denied her right to make a civilian arrest.[23]

Another option which police might advise the woman that she can exercise is that of obtaining a protective order.

To improve police response, the following suggestions are made in the literature. Several observers suggest that often police discretion should be limited, with clear-cut guidelines for making arrests. Fleming suggests that arrests be made on the basis of

[16] International Association of Chiefs of Police "Training Key," in *Battered Women*, ed. Martin Roy, p. 149 (hereafter cited as "Chiefs of Police Training Key").
[17] Morton Bard and Harriet Connally, "The Police and Family Violence: Policy and Practice," *Battered Women: Issues of Public Policy*, p. 308.
[18] "Chiefs of Police Training Key," p. 150.
[19] Fleming, *Stopping Wife Abuse*, p. 19.
[20] Martin, *Battered Wives*, p. 91.
[21] Ibid.
[22] Fromson, "The Case For Legal Remedies," p. 154.
[23] Ibid. 147.

the crime committed, regardless of the relationship of the abuser to the abused. Furthermore, she continues, police should be no less willing to arrest in domestic cases than in incidents with equivalent levels of violence between two strangers.[24] Fromson suggests that to assist police in making arrests, regulations can be written clearly to aid police officers in identifying the circumstances which constitute "reasonable" or "due cause" for arrest, taking into consideration signs of physical injury, the presence of weapons, violent conduct in their presence, the desires of the victim and outstanding orders of protection.[25]

Additionally, Fleming suggests that police improve methods for documenting calls, recording the relationship of the assailant and the victim and collecting necessary evidence that can be used in subsequent trial.[26]

If the abuser has been arrested, or if the victim decides to file a criminal complaint directly with the prosecuting attorney's office, the victim may encounter obstacles. These obstacles may result from the attitudes or beliefs held by police, prosecutors, and judges about the victim's willingess to follow through on charges, the likelihood of obtaining a conviction, the effectiveness of prosecuting a wage earner, and a general policy of the justice system toward nonintervention in family-related crimes. Additionally, according to Fleming, the filing of charges is a lengthy and complicated process that does not provide immediate protection for the victim and might not end in prosecution.[27]

Police are often reluctant to make an arrest because the victim has been uncooperative or because past experience shows that victims often do not follow through as complainants in the prosecution of spouse abuse cases. Additionally, police often lack training to investigate wife abuse cases and fail to collect necessary evidence. Without evidence, the prosecutor must rely heavily on testimony of the victim who is very often the only witness,[28] and who frequently finds herself in the position of convincing the prosecutor of the seriousness of the crime.[29]

Ultimately, the decision to prosecute rests with the prosecuting attorney and is greatly affected by his or her assessment of the victim as a witness. The decision to prosecute is made on the basis of the prosecutor's "own values, their perception of society's view of the crime charged, and likelihood of success in getting a conviction."[30] Eisenberg and Micklow suggest that factors affecting the prosecutor's decision to proceed with criminal charges are the belief that wife abuse is not a criminal problem, but a social one and therefore "not appropriate for solution through the criminal process" and the "lack of prestige associated with the prosection of these cases."[31] Furthermore, prosecutors may encourage battered women to drop charges because of their past experience in which victims did not follow through on their complaints.[32]

According to Marjory Fields, "It is generally agreed that more than half the battered wife complainants either fail to cooperate with the prosecutor or request that charges be withdrawn."[33] The reasons for the battered woman's reluctance to press charges or to follow through once charges have been made are cited in the literature. According to *Response,* "Many battered women are ambivalent about bringing criminal charges even when beatings are chronic and even if they are determined to stop the abuse."[34] According to Fleming, "The fear of reprisals and genuine concern for the accused forces many women to reconsider the wisdom of prosecuting even seriously abusive spouses."[35] Additionally, the woman's decision not to follow through with criminal charges can be influenced by the fact that she may be continuing to live with her assailant and may also be economically dependent on him.[36]

Murray Straus summarizes the situation by saying that the lack of followthrough on the part of the victim provides a:

> ready excuse for the police, prosecuting attorney, and judges to follow their "natural" inclinations of treating wife beating as "domestic disturbances" (i.e., not really a crime) rather than as assaults. This in turn sets up a vicious cycle. Since the cases are defined as not really crimes, or as crimes not likely to be successfully prosecuted, women

[24] Fleming, *Stopping Wife Abuse,* p. 192.
[25] Fromson, "The Case for Legal Remedies," p. 161.
[26] Fleming, *Stopping Wife Abuse,* p. 230.
[27] Ibid., p. 197.
[28] Ibid.
[29] Martin, *Battered Wives,* p. 112.
[30] Fleming, *Stopping Wife Abuse,* p. 198.
[31] Eisenburg and Micklow, *The Assaulted Wife: Catch 22 Revisited,* 3 Women's Digest L. Rep. 156 (1977).
[32] Fields, "Government Intervention," p. 249.
[33] Ibid., p. 249.
[34] Response, vol. 3, no. 4., p. 2.
[35] Fleming, *Stopping Wife Abuse,* p. 19.
[36] Martin, *Battered Wives,* p. 115.

are discouraged from filing charges and encounter foot dragging when they attempt to pursue such charges. As a result, the many who would bring charges if not dissauded, or who would follow through if obstacles and foot dragging did not occur, do not.[37]

Prosecutors often divert wife abuse cases from trial. In some instances, prosecutors will not proceed with criminal charges unless divorce proceedings have also been initiated. In some localities wife abuse cases are automatically referred to a family bureau or a domestic division of a district attorney's office where informal hearings often dispose of them.[38] Another form of diversion at the prosecutorial level, according to Marjory Fields, is referral to independent community mediation and arbitration services. Victims may also be referred to other appropriate agencies in the community where counseling may be received.[39]

Fields cites drawbacks in diverting serious wife abuse cases for mediation and counseling. Whereas meditation can be effective when both parties are equals requesting help in resolving the conflict, in cases where a woman has been abused repeatedly, the decision not to prosecute can reinforce the batterer's notion that violence is acceptable. On the other hand, Fields suggests that criminal prosecution "restores some of the power balance that the husband has destroyed by his violence."[40]

In situations where abuse cases are brought to trial, the actual relief that the woman obtains is often limited. While a case is pending, the traditional practice of pretrail release of all offenders except those seen as most dangerous to society-at-large will prevail in most localities. Martin suggests that although judges have the option of removing a violent husband from his home, they are reluctant to do this because of the perceived detrimental effect on the family created by the absence of the father. Thus, while the woman is awaiting trial, she may be forced to continue to live with her assailant unless she seeks protection in a shelter or other temporary residence.[41]

Fields suggests that once a case is brought to trial, although judges normally see only the most serious cases (the others having been diverted or dropped), their response often reflects the attitude that "there had been no attempts to screen out cases on the police and prosecutor level."[42] Responses from judges to these cases may reflect the same attitude that "domestic violence is a private matter which does not belong in a court of law" exhibited by other justice personnel.[43] Martin suggests that, despite the severity of the violence, the desire to see couples reconcile is often expressed by judges.[44] In sum, according to Fromson, due to a:

> belief in reconciliation, skeptism of the woman's story, and reluctance to imprison wage earners, often judges dispose of women abuse cases by releasing men on bail or their recognizance. Sometimes overly light penalties such as unsupervised probation or fines are imposed.[45]

The Civil Justice System

The criminal remedies available to battered women, then, often do not provide immediate protection. In an effort to obtain needed protection, victims might seek some form of civil relief. According to Fromson, the forms of civil relief available to victims are "various types of injunctive orders, money damages and actions related to the marital relationship such as divorce, separation and support." The availability of the relief varies, however, from State to State, as do procedures for obtainment and enforcement.[46] Also, according to Fields, in many States civil injunctions or restraining orders against the spouse are available only with a pending divorce. The result is that in many localities available civil remedies meet neither the emergency nor the ongoing justice needs of victims.[47]

One form of injunctive relief available to some victims is the protective order. This order may command the assailant to cease and desist from offensive conduct as well as order counseling, remove the abuser from the home, grant one-party custody of the children, or set vistation conditions.[48] Most injunctions are issued after a hearing and in some localities temporary orders can be obtained prior to a hearing. Enforcement of the order is by

[37] Murray Straus, "Wife Beating: Causes, Treatment & Research Needs," prepared for the U.S. Commission on Civil Rights, January 1978, p. 16.
[38] Fleming, *Stopping Wife Abuse*, p. 209.
[39] Fields, "Government Intervention," p. 251.
[40] Ibid., p. 116.
[41] Martin, *Battered Wives*, p. 116.
[42] Fields, "Government Intervention," p. 257.
[43] Fromson, "The Case for Legal Remedies," p. 151.
[44] Martin, *Battered Wives*, p. 116.
[45] Fromson, "The Case for Legal Remedies," p. 151.
[46] Ibid., p. 151.
[47] Fields, "Government Intervention," p. 257.
[48] Ibid., p. 269.

police and courts, and "violation may result in contempt charges and possible imprisonment."[49] According to Fromson, though "a broad scheme of protective orders with immediate enforcement mechanisms and stringent sanctions should meet an abused women's need for protection," there are several obstacles.[50] First, in many localities, injunctive relief is conditioned on divorce or separation. Second, to have an order issued, the victim must file a petition, appear in court, incur court costs, experience normal court delays, and testify as to why the restraining order should be issued. While awaiting a hearing, the woman most likely receives no protection. Additionally, in many localities, access to family court is not available evenings or weekends.[51] A woman who is not deterred by the complexities of obtaining a protective order may discover that the police are reluctant to enforce the order owing to a lack of clarity about jurisdiction in enforcing a civil court order. Instead of enforcing the order, police might advise her to institute contempt proceedings, which require filing another petition and encountering further delays.[52]

The victim might also sue for damages and divorce. Traditionally, husbands and wives could not sue each other for damages under the common law doctrine of interspousal immunity, which recognizes "husbands and wives as a single entity."[53] Wives living in States that have abolished this doctrine and women not married to their assailants can sue for monetary damages because of physical or emotional injuries from battering. The drawbacks of this remedy are that it is a "relatively long, and fairly complex procedure usually requiring a lawyer and attorney's fees."[54]

Divorce may also have limited usefulness to victims. Financial, religious, or social reasons might deter a woman from divorce.[55] Furthermore, the process is often slow, thus not meeting the need for immediate protection. Provisions for emergency protection, according to Fields, are often nonexistent when initiating a divorce proceeding. Judges are not eager to eject a man from his house.[56] The woman, therefore, may be forced to leave, for her own protection, thus subjecting herself to possible abandonment charges. Furthermore, regulations concerning proof of cruelty, abandonment, and ascertainment of fault also might hinder the speed with which a victim can pursue this avenue of relief.[57] The effect a divorce might have on the husband's obligation to support, and the lack of consistent support enforcement procedures, might also limit the usefulness of this remedy.[58]

Training and Education

Training is needed to improve the response of police, prosecutors, and judges to spouse abuse. As described above, traditionally, police training has tended to equip officers with skills to "cool down" a situation and minimize involvement. More recent training methods have provided police with specific skills to deal with battering cases. According to Fleming, the New York City Police Department developed a training model that gives officers skills in crisis intervention and conflict management. The thrust of this training is to maintain the family unit through counseling, referral, and mediation.[59]

The New York City model has been used as a basis for police training programs in many localities throughout the country. Although the model trains police officers in necessary intervention skills, it does not provide guidelines for differentiating between the serious domestic disturbance calls in which protection is necessary and the less serious cases in which mediation and reconciliation is preferable.[60]

For police training to be most responsive to the victims' protection needs, Fromson suggests training must emphasize the serious and unique nature of the abuse received by women and also accomodate the officer's concern for personal safety.[61] To facilitate this approach, guidelines for making an arrest, documenting the circumstances of the call, and obtaining necessary evidence to proceed with an arrest when warranted are necessary, Fleming maintains. Training should also teach police officers about community resources.[62]

[49] Fromson, "The Case for Legal Remedies," p. 152.
[50] Ibid., p. 157.
[51] Fields, "Government Intervention," p. 269.
[52] Martin, *Battered Wives*, p. 15.
[53] Fromson, "The Case for Legal Remedies," p. 157.
[54] Fleming, *Stopping Wife Abuse*, p. 170.
[55] Fromson, "The Case For Legal Remedies," pp. 152–53.
[56] Fields, "Government Intervention," p. 272.
[57] Ibid.
[58] Fleming, *Stopping Wife Abuse*, p. 170.
[59] Ibid.
[60] Ibid. Fields, "Government Intervention," pp. 231–33.
[61] Fromson, "The Case for Legal Remedies," p. 160.
[62] Fleming, *Stopping Wife Abuse*, pp. 229–30.

Fleming suggests that training of prosecutors should include knowledge about the causes, seriousness, and extent of wife abuse problems as well as the usefulness of threatening prosecution in preventing repeated attacks.[63] Additionally, prosecutors could be trained to interview in a sensitive manner that would convey an awareness of the victim's situation and her possible ambivalence about the abuser as well as her hesitancy to use the criminal justice system. Prosecutors could also inform the woman about the legal process and her rights.[64]

Training of judges is also essential. Not only do they sentence abusers, they also decide who is eligible for a divorce, the amount of support payments a father must pay, or when a woman is entitled to compensation for unpaid labor in the home.[65] Furthermore, judges have the authority to compel police and prosecutors to protect battered wives.[66] The training of judges should contribute to their knowledge about spouse abuse so that the decisions they make will reflect an understanding of its complexities.

On a broader level, law school curricula could incorporate women's issues into the basic course requirements. Additionally, family law courses that focus mainly on divorce should be broadened to include a wide range of issues relevant to battered women.[67]

Advocacy and Legal Assistance

Because of the complexities of civil and criminal remedies, as well as the lack of consistent procedures, laws, and regulations, victim advocacy on both the individual and systemic level is needed. On an individual level, legal counseling and assistance for the victim as she works through the justice system are necessary. According to Fields, the lack of free legal services often compounds the woman's civil legal problems. Fields points out that eligibility criteria that include a husband's income as a resource can disqualify a woman for legal assistance. Furthermore, Fields suggests that, even when a woman is eligible, she may have to wait a long time for service, and the services available are limited and do not provide for the emergency aspect of the domestic violence victim's legal needs.[68]

A committee on battered women in Colorado has proposed a legal clinic system that would provide legal counsel in civil, criminal, and administrative areas and also do advocacy. Advocacy could include providing an escort through family court, sensitizing the prosecutor to issues concerning battered women, and providing multilingual services when necessary.[69] Fleming also suggests that advocacy on the prosecutorial level could include assistance in tracking down witnesses and helping both the victim and prosecutor prepare for trial.[70] The Colorado Committee has suggested that advocacy on the prosecutorial level is particularly important in cases where a woman has used violence as "a means of extricating herself from an intolerable battering situation."[71] Fields also stresses the need for direct advocacy. She states that "family law practitioners should act as victim advocates with police and prosecutors to insure that their clients are protected."[72]

On a systemic level, respondents in the needs assessment suggested that advocacy for battered women should be focused on the legislative process. Legislative reform has occurred in some places and in others it is pending. Advocates of battered women have often been instrumental in bringing about needed reform. Such reform has included:

- Streamlining criminal court procedures in assault and battery cases;
- Developing improved data collection and reporting procedures;
- Improving procedures regarding enforcement of restraining orders by the police;
- Repealing intraspousal tort and immunity laws; and
- Modifying arrest procedures in misdemeanor cases.[73]

[63] Ibid., p. 232.
[64] Response, vol. 3, no. 4, p. 2.
[65] Fleming, *Stopping Wife Abuse*, p. 213.
[66] Fields, "Government Intervention," p.256.
[67] Colorado Association for Aid to Battered Women, *A Monograph on Services to Battered Women* (DHEW Publication No. (OHDS) 12/12/78) p. 209 (hereafter cited as Denver Mongraph).
[68] Fields, "Government Intervention," pp. 273–74.
[69] Denver Mongraph, p. 209.
[70] Fleming, *Stopping Wife Abuse*, pp. 209–10.
[71] Denver Monograph, p. 209.
[72] Fields, *What To Do Until the Police Arrive*, 3 Fam. L. Rep. 4027 (1977).
[73] Fleming, *Stopping Wife Abuse*, p. 241.

Selected Federal Programs Addressing Justice Needs

Core Programs

Legal Services Corporation

The Legal Services Corporation (LSC), a private nonprofit corporation, was established by Congress in 1974 to provide civil legal assistance to low-income people.[74]

LSC gives grants to 335 legal assistance programs across the country that provide direct civil legal assistance to eligible clients. Local programs have considerable authority to determine the eligibility requirements for clients, within the income limits of 125 percent of the Office of Management and Budget povery level.[75] Within parameters set by the Corporation's governing statute, local programs are relatively autonomous in determining the kinds of cases that they will accept; consequently, the types of legal matters that they address vary from one locality to another.[76] Legal assistance generally cannot be provided in fee-generating cases, non-therapeutic abortion cases, selective service or armed service desertion violations, or school desegregation cases.[77] To support local programs, LSC has established several national backup centers, including the National Center on Women and Family Law. LSC has also funded several demonstration projects, as well as research, training, and quality improvement projects.[78] (See appendix B.)

The Legal Services Corporation, under existing legislation, can play a major role in meeting the legal needs of abused women, primarily regarding civil matters and advocacy. The victim can seek aid from legal assistance attorneys in civil matters dealing with some form of injunctive relief, such as restraining or protective orders. These attorneys can also be consulted on matters concerning the termination of a marriage or relationship such as a separation agreement, child support, custody, divorce, and alimony. With respect to criminal matters, the regulations do not prevent a legal services attorney from advising a women about how to file a criminal abuse complaint in a criminal spouse abuse case, although the local prosecuting attorney is the one who actually prosecutes. Legal services attorneys can also be involved in class action litigation on behalf of battered women if approval is received from the local project director.

Family law has not been a priority of the Legal Services Corporation[79] That factor and the flexibility allowed local programs mean that domestic relations legal services have not been available in all local programs. In addition, if a local program defines family law narrowly, the abuse victim may not receive much help. In some localities, family law means only divorce cases, which are a low priority. Many programs have no provision for emergency legal assistance in family law cases. In most substantive areas, local programs establish criteria for emergency legal assistance. In housing and welfare cases, for example, lack of money or shelter is such a criterion. However, in family law cases, although the battered woman might be in a life-threatening situation, often no emergency provisions exist.[80] Furthermore, if divorce is the primary service requested by a battered woman, there may be no recognition that related services such as restraining orders or protective orders are needed. The result of defining family law narrowly is that often the battered woman's request for legal service, which might be presented as a divorce request and not perceived as an emergency by the receptionist who takes the request, is turned away or placed on a long waiting list.

The current eligibility requirements set by the Legal Services Corporation Act pose a barrier to the receipt of legal assistance by some victims. Because the Corporation's governing statute establishes a maximum income level, some victims of violence are automatically excluded. Although the eligibility criteria appear to have flexibility since factors other than income can be considered, victims of violence might still be excluded by local programs that have broad authority to interpret the requirements. For instance, programs can lower maximum income levels. Furthermore, a local program might not make provision for extenuating circumstances that may exist in determining a battered woman's in-

[74] 42 U.S.C. §§2996–2996l (1976 and Supp. 1977).
[75] 45 C.F.R. §1611.3(a) & (b)(1979).
[76] Jeanne Connelly, Office of Government Relations, Legal Services Corporation, interview in Washington, D.C., Oct. 17, 1979 (hereafter cited as Connelly Interview).
[77] 42 U.S.C. §2996f(b)(1976 and Supp. 1977).
[78] Connelly Interview.
[79] Laurie Woods, director, National Center on Women and Family Law, telephone interview, Oct. 29, 1979 (hereafter cited as Woods Interview).
[80] Ibid.

come. If the income of the battered woman's husband is included in determining eligibility, she might be found ineligible even if her husband's income is inaccessible to her.[81]

In the needs assessment and literaure review, long waiting lists and the lack of emergency response on the part of legal services attorneys were identified as problems. Portions of the problem—priority setting and lack of clarification about extenuating circumstances regarding eligibility—have been described above. The reality of the situation is, however, that often legal services attorneys are overloaded. One alternative is better utilization of other available legal services. The Corporation is currently studying other methods of legal services delivery. In the area of spouse abuse, if the Corporation endorsed contracting with private attorneys or private law firms for emergency cases of spouse abuse, legal assistance would be more available to victims. However, if the private sector were to assume more responsibility for cases of spouse abuse, members of local bar associations would need to be educated about the special legal needs of battered women.[82]

The National Center on Women and Family Law, mentioned earlier, has set addressing the problem of violence against women in domestic relationships as a priority in its first year of operation. According to its director, the center was created in response to the requests of many legal service attorneys handling family law cases who do not have the necessary information and expertise.[83] Although family law cases constitute over one-third of the legal services caseload, these attorneys have often been working in isolation, without benefit of a communication network or backup center.[84]

Historically, family law, which often involves women's issues and can encompass divorce, custody, child support, and the termination of parental rights, has not received priority attention from the Legal Services Corporation, even though this area of law comprises the largest percentage of cases handled by legal services attorneys.[85] The reasons for this situation are numerous. Family law is not often perceived as an interesting area or one in which major impact can be made on behalf of poor people and, therefore, appropriate for legal services intervention. Additionally, the focus of LSC programs in the past has been on advocacy for the low-income person in an unequal positon vis-a-vis the State. Legal Services has challenged the State on behalf of the poor in areas of welfare rights, housing law, health issues, employment discrimination, deprivation of welfare benefits, and consumer law, but not regarding battered women. Involvement with intra-family issues can be perceived by attorneys as divisive to poor people. The new backup center is expected to heighten awareness about family law as a priority issue.[86]

In addition to helping local programs with the complexities of family law, the center is expected to provide outreach and community education as well as legislative advocacy at the request of government agencies or clients. The center is also collecting data on legal services activity in the areas of spouse abuse violence and special problems encountered by clients.[87]

The director of the center hopes that it will have the resources to be involved in legislative advocacy such as the analysis of model legislation regarding civil remedies available to battered women. The center can then assist legislators upon request by providing necessary information that will improve restrictive statutes or aid in drafting new legislation[88] This function is crucial because of the variances in State statutes regarding battered women, divorce procedures, protective orders, and other methods of injunctive relief. These variances make it difficult to establish a single approach to managing the legal problems victims face throughout the country.[89] The center can also take a leadership role in determining how to use class action suits effectively on behalf of battered women to assure that they are receiving equal and fair protection under the law. This would include involvement in test litigation, when possible, as well as assistance to local offices in filing necessary briefs and providing background information.

[81] Connelly Interview.
[82] Ibid.
[83] Woods Interview.
[84] Marjorie Fields, attorney, Brooklyn Legal Services Corporation, telephone interview on Oct. 26, 1979 (hereafter cited as Fields Interview).
[85] Woods Interview; Fields Interview.
[86] Woods Interview.
[87] Ibid.
[88] Fields Interview.
[89] Connelly Interview.

The funding of the center for fiscal year 1980 is $150,000, a low level compared to the major national backup centers.[90] This funding does not even support enough staff to answer the telephone and written requests for information from local field staff.[91]

Law Enforcement Assistance Administration: National Priority Grants Program and Discretionary Grants Program

The discretionary grants program of the Law Enforcement Assistance Administration (LEAA), which is in the U.S. Department of Justice, was originally established under the Omnibus Crime Control and Safe Streets Act of 1968.[92] Under the Justice System Improvement Act of 1979, signed into law by President Carter on December 27, 1979, the programs that had been supported under this portion of the Omnibus Crime Control Act are subdivided into the national priority grants and discretionary grants programs.[93] In general, the purpose of these programs is to develop, identify, and replicate innovative and effective criminal justice practices. Each of the two programs will receive 10 percent of the total appropriation for LEAA; however LEAA received no appropriation for programs in fiscal year 1981.[94] (These programs are described fully in appendix B.)

The program announcement describing the national priority programs and discretionary grants available from LEAA included 15 national priority programs and 15 additional discretionary grants programs, totaling more than $100 million.[95] Only a small portion of the annual appropriation is used for projects that have an impact on battered women.[96] Most notable is the family violence program, a national priority program, which received in FY 1980 a total of $3 million in funding—$1 million from the national priority program and $2 million in discretionary grants.[97] These funds were used solely to continue the existing grants in this program; no new grants were planned for fiscal year 1981.[98]

LEAA's family violence program is designed to provide a comprehensive approach to the problem of "violence which occurs between members of the same family or between persons who live together in the same household. This includes spouse abuse, child abuse, sexual abuse of children, abuse of parents by children, and other forms of intra-family violence."[99] Its purpose is to improve the effectiveness of the criminal justice system in spouse abuse cases. It encourages the development of community-wide approaches involving the active participation of all relevant criminal justice, social service, medical, and mental health agencies and can also include training for criminal justice personnel.

Under this program, LEAA is supporting 20 local projects, 3 national-level domestic violence projects, and 2 grants to major medical centers to address the problem of sexual abuse of children.[100] The local projects provide a wide range of services and approaches to the problem of spouse abuse. The national level projects include grants to:

- The Police Executive Research Forum to examine the police role in the area of domestic violence;
- The American Home Economics Association to develop family violence public education materials focused on prevention; and
- The Center for Women Policy Studies for technical assistance to the family violence program.

The technical assistance grant to the Center for Women Policy Studies supports onsite assistance to the family violence program grantees, distribution of information to public and private agencies, and contact with Federal agencies involved with domestic violence.

Through these projects, LEAA seeks to achieve the following results:

[90] Woods Interview.
[91] Ibid.
[92] 42 U.S.C.A. §§3731-37, 3741-47 (1977 and Supp. 1979).
[93] Pub. L. No. 96-157, 93 Stat. 1167 (1979).
[94] George H. Bohlinger III, Acting Assistant Administrator, Office of Criminal Justice Programs, Law Enforcement Assistance Administration, letter to Louis Nunez, Staff Director, U.S. Commission on Civil Rights, Oct. 14, 1980 (hereafter cited as Bohlinger Letter).
[95] U.S., Department of Justice, Office of Justice Assistance, Research and Statistics, Law Enforcement Assistance Administration, Bureau of Justice Statistics, "National Priority Program and Discretionary Program Announcement," *Federal Register* vol. 45, no. 33, Feb. 15, 1980, part 6, pp. 10702-17.
[96] Ibid.; also, Jeannie Niedermeyer Santos, Family Violence Program Manager, and Ken Carpenter, Director, Special Programs Divison, Law Enforcement Assistance Administration, interview in Washington, D.C., Dec. 11, 1979 (hereafter cited as Santos Interview).
[97] Bohlinger Letter.
[98] Santos Interview.
[99] U.S., Department of Justice, Law Enforcement Assistance Administration, *Guideline Manual: Guide for Discretionary Grant Programs*, M 4500.1G, chap. 1, par. 4, Sept. 30, 1978, p. 19 (hereafter cited as M 4500.1G).
[100] Santos Interview.

- Reduce community acceptance of intrafamily violence;
- Increase reporting and documentation of incidents of family violence;
- Demonstrate an effective mechanism for institutional coordination among police, prosecutors, protective services, welfare, hospitals, community mental health, and other agencies and organizations to respond to family violence situations;
- Document the needs of these families and develop methods to address these needs, including reallocating existing services and creating new services;
- Improve knowledge, skills, and cooperation of medical and social service agency personnel in the collection and transmission of evidence and information to the legal system in cases of family violence;
- Reduce the number of repeat calls to police related to family disturbances;
- Increase the prosecution of cases involving repeated severe violence;
- Establish community corrections, pretrial diversion, and other programs to improve the criminal justice system's handling of these cases; and
- Reduce the number of intrafamily homicides and serious assaults.[101]

Some of the LEAA projects are also being supported by the Community Services Administration and DHHS's Office on Domestic Violence, which has expanded the scope of the technical assistance grant to the Center for Women Policy Studies into the areas of health and social welfare.[102]

Under the family violence program there are clearly no legislative or regulatory barriers to serving the justice needs of battered women. However, a single person, the program manager, is solely responsible for the entire program, leaving little time to explore new areas of need in this field.[103]

Law Enforcement Assistance Administration: Formula Grant Program

The major LEAA program under the Justice System Improvement Act of 1979 is the formula grant program, which replaces the block grant program under the prior legislation. The purpose of this program is "to assist States and units of local government in carrying out specific innovative programs which are of proven effectiveness, have a record of proven success, or which offer a high probability of improving the functioning of the criminal justice system."[104] Grants for this purpose are awarded to State criminal justice councils, which award subgrants to local governments, State agencies, and private organizations. The funds are distributed to the States on the basis of one of two formulas, and some units of local government are eligible for a formula grant from the State criminal justice council. (See appendix B for details.)

The legislation authorizes use of these funds to support programs for 23 specific purposes. Spouse abuse is not specifically included; however, several of the program areas authorized are closely related to and could support the development of spouse abuse projects. They include:

- Establishing community and neighborhood programs to deal with crime and delinquency;
- Improving police utilization of community resources through joint police-community projects to prevent or control neighborhood crime;
- Increasing the use and development of alternatives to the prosecution of selected offenders; and
- Developing and implementing programs that aid victims, witnesses, and jurors, including restitution by offenders, programs encouraging victim and witness participation in the criminal justice system, and programs to prevent retribution against or intimidation of witnesses by persons charged with or convicted of crime.[105]

Because of the autonomy of the States in determining the use of the formula grant funds, it is difficult to tell how many of the States are supporting spouse abuse projects with LEAA funds. The Center for Women Policy Studies found that a number of shelters report receiving LEAA support. Some of these are participants in the family violence program, while others are being supported by State grants.[106]

One barrier that inhibits States from allocating funds to programs for battered women is the inadequate documentation of the problem. In the guidelines for the family violence program, LEAA states:

[101] M 4500.1G, pp. 19–20.
[102] Santos Interview.
[103] Response, vol. 3, no. 3 (November 1979); Santos Interview.
[104] Pub. L. No. 96–157, §401(a)(1979).
[105] *Id.*

[106] This listing of programs was obtained from the Center for Women Policy Studies, Washington, D.C., which has a grant from LEAA to provide technical assistance to local shelter programs.

Because of the nature of these crimes, most go unreported; for those that do come to the attention of the authorities, documentation is inadequate or non-existent, making it impossible to determine the actual incidence of crime. However, the few statistics and estimates that are available show that there is a shockingly high incidence of these crimes and that they present a tremendous burden to the justice system in terms of assaults and homicides of police officers and utlization of police resources. The justice system, as well as the medical and social services system, have given these problems low priority and have failed to adequately respond to the needs of these families.[107]

A second major barrier to supporting programs for spouse abuse victims under the formula grant program is the reduction in funding for this program in fiscal year 1980. The total amount appropriated was $239.2 million, in contrast to the appropriation of $346.7 million in FY 1979.[108] In most States the available funds were used primarily to continue existing grants. Although the formula grants funds may be used for up to 100 percent of the project cost in fiscal year 1980, in subsequent years (if funds are appropriated) no more than 90 percent of the total project costs may be supported, with the remaining 10 percent "match" being required in cash. This requirement may make it difficult for some organizations serving battered women to receive support from LEAA funds.

Other Relevant Programs

AFDC Emergency Assistance

In the 21 States that provide for emergency assistance in their AFDC plan, eligible recipients may receive legal services that "meet needs attributable to the emergency or unusual crisis situation."[109] The legal needs of eligible battered women may be partially met through this program.

Bureau of Indian Affairs Social Welfare Programs

The family and community services of BIA include investigation of alleged child and adult abuse, provision of social information relevant to case disposition, and services requested by courts such as counseling and probation. Battered Native American women and their families may be served in the 15 States in which the program operates.[110]

Community Development Block Grants Program

The CDBG program operated by the Department of Housing and Urban Development is highly flexible. In areas affected by community development activities, CDBG funds may be used for employment, crime prevention, child care, health, drug abuse, education, welfare, or recreation services if these services are otherwise unavailable. CDBG funds may also be used to match other Federal funds, thus overcoming one of the possible barriers to using LEAA formula grants monies to meet the needs of battered women.[111]

Title XX

States have broad latitude in determining the kinds of services to be provided with Title XX funds.[112] Civil legal services were provided by 29 States in fiscal year 1979 at an estimated total cost of almost $30 million.[113] These services included child support, divorce, adoption, housing, civil rights, employment, guardianship, and institutional commitment. These services are avaiable to individuals in the eligibility categories established by the States, and battered women would appear to be eligible in many instances.

National Institute of Justice

Part B of the Justice System Improvement Act of 1979 creates the National Institute of Justice (NIJ) "to engage in and encourage research and development to improve and strengthen the criminal justice system and related aspects of the civil justice system" among other functions.[114] In particular, NIJ is authorized to focus research on "the problems of victims and witnesses of crime, the feasibility and consequences of allowing victims to participate in criminal justice decisionmaking. . .and procedures and programs which increase the victim's participation in the criminal justice process. . . ."[115] Since spouse abuse is both a criminal and civil justice concern that involves numerous problems affecting

[107] M 4500.1G, chap. 1, par. 4, Sept. 30, 1978, p.19.
[108] Phyllis Black, budget analyst, Office of the Comptroller, Law Enforcement Assistance Administration, telephone interview in Washington, D.C., Dec. 12, 1979.
[109] 45 C.F.R. §233.120(b)(2)(1979).
[110] 25 C.F.R. §20.24(b)(3)(1979).
[111] 42 U.S.C.A. §5305 (1977 and Supp. 1979).
[112] *Id.*, §§1397–1397f (Supp. 1979).
[113] U.S., Department of Health, Education, and Welfare, *Technical Notes: Summaries and Characteristics of States' Title XX Social Services Plans for Fiscal Year 1979* (June 15, 1979), pp. 273–77.
[114] Pub. L. No. 96–157, §201, 93 Stat. 1167(1979).
[115] *Id.*, §202(c)(2)(E).

victim cooperation, this would appear to be a fertile research topic to be examined with NIJ support.

Bureau of Justice Statistics

The Bureau of Justice Statistics (BJS) was established by part C of the Justice System Improvement Act of 1979 "to provide for and encourage the collection and analysis of statistical information concerning crime. . .juvenile delinquency, and the operation of the criminal justice system and related aspects of the civil justice system and to support the development of information and statistical systems at the Federal, State and local levels. . . ."[116] Although domestic violence is not specifically included in the legislation as a topic for the BJS to address, it is clearly within the areas of responsibility included in the act. Given the paucity of data on domestic violence, this would be a fruitful topic for BJS to examine. Some relevant data have been recently published, based on the victimization surveys sponsored by BJS.[117]

Office of Juvenile Justice and Delinquency Prevention

This office was created with LEAA by the Juvenile Justice and Delinquency Prevention Act of 1974.[118] In addition to its focus on the problems of delinquency and the juvenile justice system, including family courts, this office is supporting the national evaluation of LEAA's family violence program.

National Institute of Corrections

The National Institute of Corrections (NIC) was also created by the Juvenile Justice and Delinquency Prevention Act of 1974.[119] It is an agency of the Federal Bureau of Prisons with statutory mandates to provide training, technical assistance, research and evaluation, policy and standards formulation, and clearinghouse services to the correctional community.[120] NIC's activities have been concentrated in the areas of: "Staff Development (with an emphasis on training of correctional personnel); Field Services (probation and parole); Jails, and Offender Classification (with an emphasis on screening for risk)."[121] Although none of NIC's programs in fiscal year 1980 focuses directly on the problem of domestic violence, this problem could be addressed with NIC support, leading to more effective practices in all parts of the correctional system for working with abusers and the victims of violence. Jails and parole and probation agencies are especially likely targets for programs serving both batterers and victims, but shelters could also conceivably receive assistance. NIC is presently examining ways to assist the correctional community in coping with the problem of domestic violence.[122]

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[116] *Id.*, 301.

[117] U.S., Department of Justice, Bureau of Justice Statistics, *Intimate Victims: A Study of Violence Among Friends and Relatives.* A National Crime Survey Report SD-NCS-N-14, NCJ-62319, January 1980.

[118] 42 U.S.C.A. §§5601-5751 (1977 and Supp. 1979).

[119] 18 U.S.C. §§4351-4353 (1977).

[120] National Institute of Corrections, *Fiscal Year 1980 Program Solicitations* (July 1979), pp. 1-2.

[121] Ibid.

[122] Marian Hyler, program assistant, Correctional Services Branch, National Institute of Corrections, telephone interview, June 19, 1980.

Chapter 6

Mental Health

Assessment of Mental Health Needs

Mental health approaches to serving battered spouses and their families are rudimentary:

- Research into both the causes of spouse abuse and the mental health effects of such violence on family members is limited.
- Controversy exists concerning which members of the family are in need of mental health support.
- Knowledge of successful counseling techniques with this population is limited.
- Awareness and sensitivity are lacking in the response of the helping professions to the complex issues involved in spouse abuse.
- Limited mental health resources are available to all members of the abusive family.

Practical experience suggests that varied treatment methods should be made available to the victim, the abuser, and their children. These should include, for example, individual and group counseling, peer support groups, and couple and family counseling, and should provide for crisis, short-term, and long-term mental health needs of all family members.

Through the literature review and telephone consultations, several specific mental health needs were identified: training of mental health professionals, crisis intervention services, short- and long-term counseling, prevention, and research.

Training of Mental Health Professionals

The need for special training for the helping professions in the causes and treatment of family violence is well-documented in the literature. It is suggested that the traditional responses to battered women's pleas for help often have not been effective in meeting their needs. Mental health treatment providers have customarily been psychiatrists, psychologists, and social workers who are self-employed or employed by institutions such as hospitals or public and private social service agencies. Some critics of the treatment provided have pointed to the underlying views that some professionals have of women as provokers of violence against themselves.[1] Jennifer Fleming states that from Freud, who held that the right of possession over a woman is the essence of monogamy, to Deutsch, who believed that masochism is the most elemental power in female life, to modern clinicians such as John R. Lien, of the University of Maryland, who writes of wives gaining sustenance from masochistic involvement in violent relationships, theoretical and professional sanctions for male violence against women have been put forth. This view of women has been supported by legal, social, and cultural norms predating by centuries the development of psychological theory.[2] Fleming goes on to say that "the traditional analysis of female psychology thus. . .ensures that those in the helping professions

[1] Russell Dobash and Rebecca E. Dobash, "With Friends Like These Who Needs Enemies: Institutional Support for the Patriarchy and Violence Against Women" (paper presented at the Ninth World Congress of Sociology, Uppsala, Sweden, August 1978).

[2] Jennifer Baker Fleming, *Stopping Wife Abuse*, (Garden City, N.Y.: Anchor Press/Doubleday, 1979), p. 76.

51

will do their part to perpetuate the established social order."[3]

Dobash and Dobash discussed these more traditional methods of treatment in a paper presented at the Ninth World Congress of Sociology in Sweden. According to them, the traditional focus of many doctors and social workers has been towards preserving the family, which, in all cases, might not be in the best interest of the battered woman.[4] Furthermore, they suggest that training in these traditional methods often desensitizes social workers to reports of violence in multiproblem families or causes them to downplay their significance.[5] They cite the following, from an article by Beverly Nichols, a family caseworker in Massachusetts: "though physical abusiveness is a common complaint among wives seeking help. . .caseworkers rarely pick abusiveness as the focus of their intervention; rather they tend to ignore this 'symptom'."[6]

Dobash and Dobash also state that social services departments:

> are not provided with enough resources, and these scarce resources must be allocated to problem cases they consider most important, and to those clients deemed to be the most desperate and deserving. As such, social service departments may attempt to conserve their scarce resources by arguing that certain problems do not require their help because no problem actually exists, the problem is not very serious, or it only affects a small number of people. . . .The social background and training of the helping professionals often leads to a detachment from the everyday lives of their clients. This detachment may lead them to think that the woman is exaggerating the severity and persistence of the violence.[7]

Del Martin further notes:

> Mental health workers with the best intentions in the world may be totally unable to comprehend the urgency of the problem if they have not experienced, or at least observed, a domestic conflict close at hand. . . .Usually by the time a mental health worker becomes involved in a case, the latest round in an on-going marital contest is already a week or ten days in the past. By that time, wounds are already healing and tempers have cooled; the very complex psychological adjustments that have enabled a couple to maintain their marriage in the face of occasional violence have already been made. The calm, contemplative setting of the office may even add to the general feeling that things went momentarily awry but are all right now—even in a marriage that has a steady history of violent outbursts.[8]

Additionally, Dobash and Dobash noted that family casework files often document wife abuse but do not focus on the battering. They maintain that caseworkers generally accept the Freudian theory of female narcissim, passivity, and masochism; thus, they tend to view the woman as a part of the cause of the assault.[9] Furthermore, social workers usually have been trained and motivated to help maintain the family intact and, therefore, do not provide sufficient advocacy when independence is the preferred choice.[10] Dr. Anne Flitcraft testified that "women come back [from community mental health centers] and [report] that they tried to get aid there and were told that their husbands were not mentally ill and there was no serious mental problem there at all."[11]

Emotional support and counseling for victims of domestic violence is often provided by staff from shelters and other grassroots organizations. Although such staff may have a greater understanding and sensitivity to the problem of spouse abuse than many professionals, they also can benefit from training in counseling. Catherine Lynch and Thomas Norris point out the importance of programs being able to provide access to supportive and clinical counseling: "The road to hell is paved with good intentions. Well meaning, but improperly trained and supervised counselors may maintain the victim in a dangerous or destructive situation. Sometimes they may even unintentionally escalate the violence."[12]

In summary, all mental health personnel need further education to broaden their understanding of wife beating. Most professionals are not trained to identify and treat the complex needs of battered women, the batterers, or other members of their families.

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[3] Ibid.

[4] Dobash and Dobash, "With Friends Like These," p. 6.

[5] Ibid., p. 25.

[6] Ibid., pp. 26–27.

[7] Ibid., pp. 25–26.

[8] Del Martin, *Battered Wives* (San Francisco: Glide Publications, 1976), p. 146.

[9] Dobash and Dobash, "With Friends Like These," pp. 27–29.

[10] Ibid., p. 30.

[11] U.S., Commission on Civil Rights, *Battered Women: Issues of Public Policy* (a consultation sponsored by the U.S. Commission on Civil Rights, Washington, D.C., Jan. 30–31, 1978) (hereafter cited as *Battered Women Consultation)*, p. 119.

[12] Catherine Lynch and Thomas Norris, "Services for Battered Women: Looking for a Perspective," *Victimology: An International Journal*, vol. 2, nos. 3–4 (1977–78), p. 558.

Crisis Intervention

Several survey respondents cited the need for mental health services that focus on easing the family through the crisis of violence. Lenore Walker notes that "crisis intervention techniques can often be used most appropriately for intensive therapy immediately following an acute battering incident."[13] Ball and Wyman add that the "first consideration must be given to the crisis aspect of. . .[the wife's] immediate situation. . . ."[14]

Crisis intervention services need to be made available on a 24-hour basis and must be immediately accessible. A New Jersey report states that "because a life might be at stake, the program must provide for 24-hour, seven day a week access and response, as well as the immediate coordination of all available resources."[15]

The New Jersey report also describes what a 24-hour crisis intervention unit should provide:

- An evaluation of the condition of the home and family;
- Crisis counseling on the scene, to include outlining the rights and responsiblities of both partners in the dispute and options they have available to them, such as legal actions, and/or the use of community resources;
- Immediate assistance to those parties who want to leave the home, including transportation to a medical facility or doctor, or to a requested social services agency (including, among others, a shelter, women's center, welfare agency, and legal aid);
- Referral to an appropriate community resource; and
- Follow-up service with the couple within 24 hours, or at a mutually agreed upon time, whether or not the couple chooses to remain together.[16]

Short- and Long-Term Counseling Support

Although most battered women's programs provide some form of short-term and long-term counseling, there is strong debate as to the best model. Many argue that peer counseling is the approach that is most likely to be successful, but the major argument has been between those who argue that the couple should be counselled together and those that believe that they should be seen separately.[17] There is no evaluative research that will resolve this issue.

Some survey respondents suggested that the peer group support found in communal living, such as in a shelter, is the most effective form of counseling. The group experience eliminates the battered woman's isolation and allows her to learn, through her association with other victim residents and staff members (who are often former victims), that her problems are not unique. Peer support encourages increased assertiveness and independence, thereby helping the victim toward a more positive self-image. Short- and long-term counseling might also take other forms, including support groups for current and former shelter members, assertiveness training, consciousness-raising groups, or individual therapy.

Walker believes group therapy, from a feminist perspective, is useful as a therapeutic tool with battered women. She states that this type of group therapy tends to reduce the feeling of uniqueness and isolation that are often experienced by battered women.[18] Lisa Leghorn reports that a sharing of experiences is the best method of providing support to victims. She views this approach as the antithesis of the more traditional "top down hierarchical relationship of counselor to counseled."[19] Those who support peer group counseling believe that the victim does not need "treatment" because she is not "sick." They suggest that, rather, the victim should be viewed as the product of a society which condones the subordination of women and ignores violence within the family and, therefore, is in need of understanding and support.[20]

The emotions and behavior caused by battering, however, may not be resolved for all women through group support alone. Fleming adds that although she feels the support group modality is the most effective for promoting the emotional indepen-

[13] Lenore Walker, *The Battered Woman* (New York: Harper and Row, 1979) p. 166.
[14] Patricia G. Ball and Elizabeth Wyman, "Battered Wives and Powerlessness; What Can Counselors Do?" *Victimology: An International Journal*, vol. 2, nos. 3-4 (1977-78), p. 546.
[15] State of New Jersey, Department of Human Services, Division of Youth and Family Services, "Physically Abused Women and Their Families, The Need for Community Services" (Trenton, N.J.: June 1, 1978), p. 55.
[16] New Jersey, "Physically Abused Women," pp. 57-58.
[17] Denver Monograph, p. 32.
[18] Walker, *The Battered Woman*, pp. 240-44.
[19] Lisa Leghorn, testimony, *Battered Women Consultation*, p. 138.
[20] Monica Erler, testimony, *Battered Woman Consultation*, pp. 112-13.

dence of battered women, many still will seek one-to-one counseling.[21] Lenore Walker notes: "The battered woman who comes to the therapist. . .is usually trying to cope with her feelings of guilt, anxiety and anger. The therapist can help her express that guilt by having her recount the details of battering incidents. . . ."[22]

Respondents varied in their approaches to involving the abuser in counseling. Many of them reported clinically experiencing the lack of motivation of many abusers to change their behavior that made them poor candidates for effective counseling. Also, a recurring theme at a recent conference on abusers was recognition that the art of treating the abuser is in its infancy. Little in the way of hard research findings sheds light on the most effective methods of treating the abuser.[23]

Some spouse abuse programs focus on the batterer alone, while others focus on the batterer within a context designed to improve the marital relationship. For example, Anne L. Ganley and Lance Harris stated in a presentation at the American Psychological Association: "At the Domestic Assault Program of American Lake Veterans Hospital, the primary goal is on the batterer's skills and deficits."[24] Goler and Walsh report that when a battered woman chooses to remain in the relationship and is successful in her attempt to involve her husband in couples therapy, counseling techniques should emphasize modeling, teaching behavior change, as opposed to analysis and psychodynamics, and the restructuring of the relationship.[25]Flax advocates couples counseling that attempts to teach control and replace violent behavior with new communication skills. In this approach, two therapists, one male and one female, work together to provide role models.[26]

It is apparent that a wide variety of counseling options must be made available in each community. These options should include group and individual counseling; peer support for victims, abusers, and children; and couples and family counseling. Without such a variety of options, the victim will not have the freedom of choice as how best to remedy her current family situation.

Prevention

The literature suggests evidence that powerful social factors have created an atmosphere in which society tolerates, and perhaps encourages, violence against women. Lenore Walker documents the inadequacies of the justice and social service systems in supporting a women's right not to be battered. She also cites early sex role socialization, and the inequities between males and females in our culture, as perpetuators of wife abuse.[27]

Dobash and Dobash state, "The causes of personality disorders and mental illness are seen as integrally related to the unsuccessful inculcation of a constellation of attitudes and behaviors appropriate to one's sex to the unhappy nature, or poor quality, of parent-child relationships, and form and content of early childhood learning."[28] Other sociocultural theories focus on socioeconomic conditions to explain battering.[29]

All the above-cited factors underscore the complexity of the measures necessary to prevent spouse abuse. Although prevention must include improving the economic condition of women in general, specific prevention measures also may include the need to encourage non-sex-role stereotyped education in the schools, and in the media, and the need to break the cycle of violence by focusing on the children currently living in abusive families.

Research

Murray Straus states: "Until recently wife-beating has been the victim of 'selective inattention' on the part of both the general public and the research community. Thus, almost any aspect needs investigation."[30] Barbara Starr also makes this point: "No subject receives more study than the family, and no

[21] Fleming, "Stopping Wife Abuse," p. 129.
[22] Walker, *The Battered Woman*, p. 238.
[23] Conference on Intervention Programs for Spouse Abusers, Belmont, Md., May 1-3, 1979 (sponsored by Special Programs Division, Law Enforcement Assistance Administration).
[24] Anne Ganley and Lane Harris, "Domestic Violence: Issues in Design and Implementing Programs for Male Batterers" (paper presented at the American Psychological Association, Toronto, Canada, Aug. 29, 1978).
[25] Denver Monograph, p. 33.
[26] Ibid.
[27] Lenore Walker, "Battered Woman and Learned Helplessness," *Victimology: An International Journal*, vol. 2, nos. 3-4. (1977-78), p. 25.
[28] Dobash and Dobash, "With Friends Like These," p. 30.
[29] Denver Monograph, p. 23.
[30] Murray Straus, "Wife Beating: Cases, Treatment and Research Needs", (prepared for U.S. Commission on Civil Rights, January 1978).

aspect of family life is studied less than family violence."[31] Dobash and Dobash reviewed the numerous flaws in much of the research on spouse abuse and state that "psychiatric papers do not vary from the general pattern of placing responsibility for wife beating upon the wife."[32]

Straus discusses the desirability of using differing research methodologies and techniques. He suggests that studies must be conducted "within a framework which views family violence as a whole, and which views family violence as an aspect of violence, as a system of social relationships characterizing the society in general."[33] He concludes that "of the types of research to be carried out in the future, the most important is a longitudinal study. . .with implications for national policy concerning the methods of reducing marital violence. It will take a longitudinal study to even come close to a clear answer."[34]

Selected Federal Programs Addressing Mental Health Needs

Core Programs

Community Mental Health Centers

The authority for the establishment and operation of federally supported community mental health centers (CMHCs) is provided by the Community Mental Health Centers Act of 1963, as amended.[35] CMHCs are public or private nonprofit agencies or organizations established to provide comprehensive mental health services to the residents of a defined geographic (catchment) area of 75,000 to 200,000 people.[36]

The Federal legislation authorizes the Secretary of Health, Education, and Welfare (now DHHS) to make grants to qualifying agencies for the planning and operation of CMHCs.[37] Approximately 750 CMHCs have been funded to provide the full range of essential mental health services under various provisions of the act.[38] Twelve "essential services" must be offered by each CMHC to be eligible to receive Federal funds.

CMHCs are mandated to provide services within the limits of their capacity to anyone living or working within the designated catchment area regardless of his or her ability to pay, and regardless of his or her previous or current health condition, or any other irrelevant factor.[39] Community mental health centers, therefore, have the mandate and potential for serving the mental health needs of battered spouses.

Little data has been collected to indicate if CMHCs are serving the abused population. Although grantees must submit an annual report that includes information on service to populations with special needs, battered women and their families have not been identified as such a group.[40]

Emergency services are one of the essential services required for receipt of Federal funding.[41] Many centers provide only a telephone answering service, while others may only provide service to one part of their catchment area. Emergency services can be very costly to operate on a 24-hour basis. For this reason, some centers purchase the service through a hospital emergency room, many staff members of which are not trained in diagnosing psychiatric emergencies beyond the obvious physical symptoms. This, of course, would be true for the symptoms of wife abuse. If the abuse is either unrecognized or the staff is uncomfortable with addressing it, the critical emergency service could be lost.

Another relevant essential service is consultation and education. CMHCs are required to share their mental health expertise with other community agencies and groups.[42] This sharing can take a number of forms, such as seminars, weekly case consultations, or staff training workshops. Such consultation services may be provided to public or private agencies, for a fee or at no cost, at the discretion of the CMHC. Shelters are the type of service agency for which this consultation service is appropriate. More

[31] Barbara Starr, "Patterns in Family Violence" (paper presented at the 105th Annual Forum of the National Conference on Social Welfare, Los Angeles, Calif., 1978).
[32] Dobash and Dobash, "With Friends Like These," p. 28.
[33] Straus, "Wife Beating," p. 52.
[34] Ibid., p. 53.
[35] 42 U.S.C.A. §§2689–2689aa (1979) (Originally enacted Oct. 31, 1963, Pub. L. No. 88–164, Title II, 77 Stat. 290).
[36] 42 U.S.C.A. §2689(a)(a)(A)(Supp. 1979); 42 C.F.R. §54.104(b)(1979).
[37] 42 U.S.C.A. §2689–2689d (Supp. 1979).
[38] Frances Premo, program analyst, Operations Branch, NIMH, telephone interview, Dec. 7, 1979.
[39] 42 U.S.C.A. §2689(a)(1)(B) (Supp. 1979).
[40] Telephone interview with Joy Schulterbrand, Chief, Center for Studies of Child and Family Mental Health, National Institute of Mental Health, DHHS.
[41] 42 U.S.C.A. §2689(b)(A)(i) (Supp. 1979).
[42] *Id.*, §2689(b)(1)(A)(iv).

formal relationships with shelters, as agencies providing services to clients in need of mental health support, and for those residing within the CMHC catchment area (i.e., clients of the CMHC by definition), could be developed through "affiliation agreements." Spreading mental health concepts and expertise is a key objective of the community mental health concept.

Regarding outpatient counseling services, many respondents to the telephone consultation said additional outreach is needed. Catchment areas are based on population and many are very large geographically, particularly in rural areas. Lack of transportation to CMHC facilities is often a barrier to the receipt of needed services. Considering the fact that battered women are often socially and geographically isolated, outreach to them is needed, especially by rural CMHCs. The CMHC is supposed to provide a program of comprehensive mental health services throughout the catchment area, not restricted to one specific location, but it often centers on a building rather than on doing outreach and providing an outstationing of services.

Outpatient services may include any form of mental health support—individual, group, couple, or family therapy. Psychotherapy through peer support groups is allowable. Outpatient services may be provided through affiliation agreements with groups such as shelters. Many CMCHs rely on individual counseling and psychodynamic techniques. The choice of treatment type is at the discretion of the center. Reliance upon psychoanalytic methods tends to attract motivated clients who are accustomed to articulating their problems. Some women in need of mental health support will not seek out services because they are reluctant to discuss the abusive situation and have difficulty in expressing their feelings about it. Such a person could also be viewed as unmotivated and, therefore, not appropriate for psychoanalytic counseling. Many mental health practitioners have been exclusively trained in psychoanalysis and, accordingly, are not comfortable with other types of counseling that would be more effective for some abused women.

The CMHC board, as legislatively mandated, calls for citizen participation.[43] Policy direction, types of clients to be served, priorities, and so on are determined by the board. Because of the public's lack of awareness of the spouse abuse problem, it is unlikely that CMHC boards will recognize this problem as a priority in their community.

The fiscal year 1981 Federal budget provides less money for CMHCs. Moreover, as the President's Commission on Mental Health noted: "Centers were developed on the premise that non-federal resources would eventually replace federal dollars as the basic source of support for the program. However, many centers which have reached, or are reaching, the end of their 8-year period of Federal funding may be forced to reduce or dismantle services."[44] Budgetary cutbacks could be a major barrier to CMHCs serving battered women, whose needs are only beginning to be recognized.

Alcoholism Prevention, Treatment, and Rehabilitation

The Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 established the National Institute on Alcohol Abuse and Alcoholism (NIAAA).[45] This act authorizes NIAAA to develop and conduct comprehensive health, education, training, research, and planning programs for the prevention and treatment of alcohol abuse and alcoholism.[46] NIAAA provides grant funds to public and nonprofit agencies to carry out its mandates.[47] These grants are expected to support, whenever possible, community-based, integrated service programs, which address prevention, treatment, and rehabilitation needs.[48] The 1976 amendments allow the Secretary to provide special consideration to applications for programs and projects for the prevention and treatment of alcohol abuse and alcoholism by women and individuals under the age of 18.[49] The 1979 amendments

[43] *Id.*, §2689(c).

[44] President's Commission on Mental Health, *Report to the President*, vol. 1, p. 19.

[45] Pub. L. No. 91-616 §101, 84 Stat. 1848 (1970-1971) (codified at 42 U.S.C. §4551 (1976)).

[46] The Act has subsequently been amended five times by acts entitled The Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act Amendments of 1974, 1976, 1977, 1978, and 1979, respectively (hereafter 1974 Amendments, etc.): 1974 Amendments, Pub. L. No. 93-282, 88 Stat. 126; 1976 Amendments, Pub. L. No. 94-371, 90 Stat. 1035; 1977 Amendments, Pub. L. No. 95-83, 91 Stat. 397; 1978 Amendments, Pub. L. No. 95-622, 92 Stat., 3437; 1979 Amendments, Pub. L. No. 96-180, 93 Stat. 1301.

[47] 42 U.S.C.A. §§4571-4578 (1977 and Supp. 1979).

[48] 42 U.S.C. §4551(a) (1976).

[49] *Id.*, §4577(b) (1976).

mandate that NIAAA services be made available to the victims of alcohol-related spouse abuse.[50]

Therefore, no legislative barriers exist that would prohibit battered spouse programs from receiving grants to set up alcoholism treatment programs. Victims of spouse abuse and families who have alcohol abuse problems are eligible to receive the services of programs funded under NIAAA.[51] In light of the evidence[52] that shows a correlation between alcohol abuse and domestic violence, there is great potential for spouse abuse programs to obtain support from the federally supported alcohol programs. The guidelines for the alcoholism treatment and rehabilitative service grants call for the involvement of the family in the treatment process.[53]

A special authorization in the 1976 amendments to the act includes support for national alcohol research centers.[54] The cause and effect relationships between alcoholism and spouse abuse is an area that needs further investigation, which could support NIAAA.

Spouse abuse program staff need to become involved in the planning of alcoholism at the Federal, State, and local levels. At the Federal level, the 1974 amendments established the Interagency Committee on Federal Activities for Alcohol Abuse and Alcoholism.[55] This Committee is supposed to evaluate and coordinate all Federal programs and activities on alcoholism and alcohol abuse.[56] The Committee includes members from those Federal agencies with programs directly affecting alcoholism and alcohol abuse,[57] but as of April 1980 did not include a representative from the Office of Domestic Violence. At the State level, a State advisory council consults with the State agency in carrying out the alcoholism plan.[58] State advisory councils could include representatives from spouse abuse programs.

Drug Abuse Prevention and Treatment

The National Institute on Drug Abuse (NIDA) was established by statute in 1972[59] to stem the increasing incidence of drug abuse in the United States, especially heroin addiction. NIDA provides funds for local programming, using as its primary funding mechanism the statewide services grants.[60] These grants are awarded through the States' designated single State agencies.[61] (The SSA also administers the State's alcoholism programs in some States.) NIDA's grant process includes incentives for local participation in drug abuse programming and encourages different types of therapy in outpatient, residential, and day care settings. NIDA funds are earmarked for prevention, treatment, research, and training programs.

NIDA-sponsored programs are frequently part of an overall drug rehabilitation service network involving community mental health centers, public hospitals, and the Veterans Administration inpatient drug facilities. Other programs, such as therapeutic communities, half-way houses, and small autonomous detoxification programs are also supported through NIDA funding; however, few services are located in rural areas. No specific eligibility requirements are imposed by NIDA for participation by individuals in local drug treatment programs.[62] Local agencies operating such programs under NIDA funds may, however, impose certain eligibility criteria based on residence and appropriateness of treatment for client needs.[63] In addition to their potential for serving abused women and abusers who have drug problems, these services may provide a resource for the identification and referral of spouse abuse cases. Consultation, training, and staff development also could be made available for shelters and other domestic violence organizations.

As of 1980, NIDA had no spouse abuse programs, but efforts were underway by administrators in NIDA and in the DHHS Office of Domestic

[50] Comprehsensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act Amendments of 1979, Pub. L. No. 96-180, § 11(a)(4), 93 Stat. 1301 (to be codified at 42 U.S.C. §4577(a)(3)).

[51] David Clough, NIAAA, interview Dec. 6, 1979.

[52] Richard Gelles, *The Violent Home* (Beverly Hills: Sage Publications, 1972).

[53] 1979 Amendments, Pub. L. No. 96-180 §§2(b)(3), 6(a)3, 6(b))1, 93 Stat. 1301 (amending 42 U.S.C. §§4541(a), 4561(a), 4561(b)).

[54] 1976 Amendments, Pub. L. No. 94-371 §7, 90 Stat. 1039 (codified at 42 U.S.C. §4588 (1976)).

[55] 1974 Amendments Pub. L. No. 93-282 §131, 88 Stat. 133 (codified at 42 U.S.C. §4553 (1976)).

[56] *Id.*

[57] *Id.*

[58] 42 U.S.C. §4573(a)(3)(1976).

[59] Drug Abuse Office and Treatment Act of 1972, Pub. L. No. 92-255, §501, 86 Stat. 85 (codified as amended at 21 U.S.C.A. §§1191-1194 (1980)).

[60] 21 U.S.C.A. §1176 (1972 and Supp. 1980); 42 C.F.R. §54(b) (1979).

[61] *Id.*

[62] Fred Norton, Office of Program Support, NIDA, telephone interview, Dec. 11, 1979.

[63] Ibid.

Violence to address drug abuse identifcation and treatment needs among spouse abuse victims.[64]

In the area of prevention, NIDA provides information, education, models for program alternatives, and direct program intervention.[65] The designated single State agency is charged with planning, coordinating, and administering prevention programs.[66] Designated prevention coordinators in each State and a national prevention evaluation resource network are being established.[67] NIDA and the National Advisory Council for Drug Abuse Prevention could aim these prevention activities at drug abuse within a family context and educate the public to the relationship between drug abuse and family problems, including violence.

Spouse abuse programs could work with drug abuse programs in the area of training. The National Drug Abuse Training Center is directed to "develop and conduct programs, conferences, meetings, seminars and other activities to develop new training and educational materials for use by the field."[68] The services and facilities of the training center are authorized to be made available to Federal, State, and local government officials and staff; to medical and paramedical personnel; and to others.[69] Therefore, battered wife programs have access to such training opportunities.

The 1979 Amendments to NIDA's enabling legislation provide special consideration to applications for special projects and grants through NIDA from organizations operating programs for the prevention and treatment of drug abuse and dependence by women.[70] The recent passage of this bill will have important implications for the development of drug abuse programs for victims of spouse abuse.

Other Relevant Programs

Community Health Centers

The community health centers provide comprehensive health care services in areas with "scarce or non-existent health care services and for populations with special health needs." Supplemental services can be provided if it has been determined by the Secretary that such services are "necessary for the adequate support of primary health services." These supplemental services include mental and public health services, including counseling, referral for assistance, and followup. Money is also available to link the CHC with the CMHC by allowing a social worker to assess the mental health needs of CHC clients and to refer those needing counseling services to the CMHC. (Further information on the CHC program can be found in appendix B.)

Department of Defense

The Department of the Navy's family advocacy program provides for an emergency response to family violence. A family advocate representative is available to provide crisis intervention. Referrals are made to existing military and civilian facilities for long-term counseling needs. Through the child advocacy programs of the Departments of the Army and Air Force, a similar mechanism is available for children in abusive situations; however, a formal spouse abuse program is not. (Further information on the programs of each of the three services can be found in appendix B.)

Veterans Administration

Certain veterans and their dependents may receive hospitalization benefits, readjustment counseling and related services, and treatment and rehabilitation for alcohol dependence, drug dependence, or abuse disabilities. Additionally, 36,600 social workers are employed by the VA's Department of Medicine and Surgery. Readjustment counseling services are now provided at the request of any veteran who served on active duty during the Vietnam era. This would include any abuser who also is eligible for VA services. (The Vietnam era is the period beginning August 5, 1964 and ending at a time determined by Presidential proclamation or concurrent resolution of the Congress.) If an assessment by a VA physician or psychologist (or, where none is available, a physician or psychologist contracting with the VA) finds that the veteran needs mental health services to readjust to civilian life, such services may be provided. If the veteran requesting readjustment counseling is determined to be ineligible, he or she may be referred to a non-VA

[64] Ibid.
[65] 21 U.S.C.A. §§1180–1193 (1972 and Supp. 1980).
[66] *Id.*, §1176(e).
[67] Susan Lachter, Communications Services Branch Chief, NIDA, telephone interview, Dec. 12, 1979.
[68] 21 U.S.C. §1179(a)–(b) (1976).
[69] *Id.*, §1179(c).
[70] 1979 Amendments to the Drug Abuse Office and Treatment Act of 1972, Pub. L. No. 96–181, §7(c), 93 Stat. 1317 (1979) (codified at 21 U.S.C.A. §1177(d) (1980)).

facility. (Further explanation of the Veterans Administration program can be found in appendix B.)

Community Development Block Grants

Although the community development block grants program is predominatly a housing program, according to the Housing and Community Development Act (Pub. L. No. 93–383), activities may be supported under both the entitlement grant and small cities program to provide otherwise unavailable services for the employment, crime prevention, child care, health, drug abuse, education, welfare, or recreation needs of residents in areas affected by community development activities. This may be a potential resource in areas where the mental health needs of abusers, victims, and children are not being served. (Further information on this program can be found in appendix B.)

Law Enforcement Assistance Administration

Part of the national priority grants program, the LEAA family violence program (FVP), is aimed at reducing and preventing violence and sexual abuse in the home. FVP includes individual, family, and marital therapy, self-help groups for victims, day care for children of preschool age, including a therapeutic milieu for those who need it, and alcohol and drug abuse programs.

Under the discretionary grant program, LEAA is authorized to award to State and local governments grants that serve several purposes, one of which is to develop and implement programs that provide assistance to victims, witnesses, and jurors, including restitution by the offender. This program has the potential for funding counseling services for victims and also for abusers in spouse abuse situations as a diversion mechanism. (These LEAA programs are further described in appendix B.)

Title XX

Services provided under Title XX may include information, referral, and counseling. Counseling could be provided to Title XX-eligible spouse abuse victims, abusers, and children. Additionally, as part of the State assistance program, funds are available for training and retraining of social services personnel. (Further information concerning this program can be found in appendix B.)

National Center of Child Abuse and Neglect

The National Center on Child Abuse and Neglect (NCCAN) provides for community-based demonstration grants, contracts, and State formula grants for the prevention and treatment of child abuse and neglect. During the period examined, NCCAN, in conjunction with the Office of Domestic Violence, funded three demonstration projects that focus on the children of spouse-abusive families. These demonstration programs and resultant training materials have the potential for aiding in the treatment and prevention needs of the children residing in violent homes.

Chapter 7

Health

Assessment of Health Needs

In the needs assessment, the battered woman's need for comprehensive medical services was discussed as a priority for victims. This need exists because victims often sustain serious physical injuries as a result of battering.

In addition, the stress created by repeated batterings places the victim in a high-risk category for developing other serious medical problems. Furthermore, the victim, embarrassed by the cause of her injuries and fearful of retaliation, often ignores her health needs as well as the health needs of her children.

To meet the medical needs that battering creates, the victim requires emergency care, crisis-intervention counseling, protection from further abuse, and referral to appropriate community health care resources. The victim also needs ongoing medical care that should include medical followup, evaluation of secondary health problems, an assessment of need for mental health support, and a medical evaluation of the victim and her children. For the victim to obtain medical treatment, physicians, emergency room personnel, and other health practitioners need training to identify battering as the cause of physical injury, and to assume professional responsibility for meeting all the needs of victims and not just the physical injuries by making appropriate community referrals.

Need for Emergency Treatment

Battered women often require emergency medical care. Their injuries follow a pattern. Based on a study of women seeking emergency room treatment at the Yale New Haven Hospital, Stark, Flitcraft, and Frazier suggest that there is a predominance of "injuries to the face, chest, breast and abdomen."[1] Lenore Walker categorizes injuries of battered women treated in emergency rooms as follows: First, serious bleeding injuries "requiring stitches to close them"; second, internal injuries causing bleeding and the malfunction of organs; third, bone injuries; and fourth, burns, such as from cigarettes, hot appliances, and scalding liquids. Walker points out that "most women who arrive in the emergency room have multiple injuries."[2]

The literature also suggests a correlation between battering and pregnancy. Stark, Flitcraft, and Frazier report that "battered women are 3 times more likely than nonbattered women to be pregnant when injuried. Consequently, these women evidenced a significantly greater number of miscarriages"[3] [than nonbattered pregnant women].

[1] Evan Stark, Anne Flitcraft, and William Frazier, "Medicine and Patriarchal Violence: The Social Construction of a 'Private' Event," *International Journal of Health Services*, vol. 9, no. 3 (1979), p. 467.

[2] Lenore Walker, *The Battered Woman* (New York: Harper & Row, 1979), p. 206.

[3] Stark, Flitcraft, and Frazier, "Medicine and Patriarchal Violence," p. 467.

The response from the medical profession has often been inappropriate and has not met the health needs of victims.[4] Consequently, the need for more sophisticated emergency room treatment by better trained staff was stressed by respondents. Studies indicate that emergency rooms provide medical services to spouse abuse victims, but often they are not identified as such by attending physicians.[5] Flitcraft reviewed the medical records of 481 women treated for injuries in March 1976 and found that they had incurred a total of 1,400 injuries; 25 percent of the women appeared to be those who were at risk of being battered.[6] Stark, Flitcraft, and Frazier analyzed the physicians' (467) diagnoses of the causes of the injuries: "Where physicians saw 1 out of 35 of their patients as battered, a more accurate approximation is 1 in 4; where they acknowledged that 1 injury out of 20 resulted from domestic abuse, the actual figure approximated 1 in 4. What they described as a rare occurrence was in reality an event of epidemic proportions." In sum, battering is several times more frequent than physicians acknowledged.[7]

Several factors appear to contribute to the problem of identification and underreporting of battering. Studies show victims seeking medical attention for only a few of the injuries they actually receive.[8] When a women does make contact with the hospital, because of the shame associated with the injury, she often camouflages the circumstances surrounding her injuries or provides "superficial" explanations for their cause.[9] Even when asked directly by a physican or other medical personnel, she may deny that she has been abused. Consequently, physicians and nurses, "feeling there is nothing else they can do. . .abandon their questioning even when the injuries do not match the woman's story."[10]

Even when the battered woman does reveal the true nature of her injuries, many physicians are reluctant to confront the battered woman directly about her situation.[11] A study of battered women by two Scottish researchers found that 75 percent of the women who visited a doctor received medical treatment for their physical injuries only. Most frequently the physician took a "neutral stance and just listened."[12]

According to researchers Dobash and Dobash, the physician's failure to become more actively involved stems from various factors. These include the doctor's training, his or her discomfort in dealing with an abusive situation, and the notion that injuries received within the family are not a public matter. Dobash and Dobash further noted that many medical practitioners treat symptoms, rather than the whole individual; thus they do not recognize that the situation is more serious than the immediate injury and requires more than symptomatic treatment.[13]

Stark, Flitcraft, and Frazier also address the problem of underreporting, misidentification, and inappropriate medical treatment by health practitioners.[14] They report that when a woman initially seeks treatment at the emergency room, the medical practitioner customarily provides symptomatic relief to emergency complaints. They suggest that often the attending emergency room physican focuses on the specific injury, in isoiation, rather than viewing the injury within the broader context of battering. Rarely, they found, did the physician note that the cause of the woman's injury was battering.[15]

At first her visits are recognized simply by recording her repeated trauma. Gradually, however, the accumulation of injuries is supplemented by physician notes about vague medical complaints. And, finally, a complex of problems is recognized, including trouble with neighbors, alcholism, drug abuse, attempted suicide, depression, fear, and a variety of alleged mental illness.[16]

They go on to say that:

[4] Ibid., passim.
[5] Ibid., pp. 466–67.
[6] Anne Flitcraft, testimony before U.S. House of Representatives, Committee on Science and Technology, Hearings on Domestic and International Scientific Planning, Analysis and Cooperation, 95th Cong., 2nd Sess. 240 (1978).
[7] Stark, Flitcraft, and Fraizer, "Medicine And Patriarchal Violence," p. 467.
[8] R. Emerson Dobash and Russell P. Dobash, "With Friends Like These Who Needs Enemies: Institutional Support for the Patriarchy and Violence Against Women" (paper presented at the Ninth World Congress of Sociology, Uppsala, Sweden, August 1978), p. 7.
[9] Ibid., pp. 7–8.
[10] Colorado Association for Aid to Battered Women, "A Monograph on Services to Battered Women" (DHEW Pub. No. (OHDS)) 78, 12/27/78) (hereafter cited as Denver Monograph), p. 30.
[11] Dobash and Dobash, "With Friends Like These," p. 8.
[12] Ibid.
[13] Ibid., pp. 8–11.
[14] Stark, Flitcraft, and Frazier, "Medicine and Patriarchal Violence," passim.
[15] Ibid., pp. 469–72.
[16] Ibid., p. 473.

The secondary problems the abused woman has developed in the course of her "treatment" provide medicine with labels they can use to organize a history of otherwise unrelated accidents. She is, after all, a drug abuser, or an alcholic, or she is suffering from one of a myriad of such female disorders as depression, hysteria, hypochondriasis, etc.[17]

This study also suggests that once the battered woman is recognized and identified as such, she is often treated for her secondary symptoms, such as those described above.[18] The authors suggest that a common notion held by the medical profession is that battering occurs more frequently to women who experience the psychiatric disorders mentioned above. Their study results, however, dispute this assumption. According to the records studied, before the "onset of abuse with the single exception of alcoholism, there are no statistically significant differences between battered and non-battered women in their rates of psychiatric disorder. . . ."[19]

Stark, Flitcraft, and Frazier suggest that treatment by emergency room staff is often provided through the prescription of drugs and referral for psychiatric treatment. According to them, "1 in 4 battered women receive minor tranquilizers or pain medications, while fewer than 1 in 10 non-battered women receive these prescriptions."[20] They continue:

The medical profession often disposes of battering by characterizing it as a psychiatric problem for the victim. Psychiatric referrals follow nonbattering injuries only 4 percent of the time, while largely unidentified victims of battery were referred 15 percent of the time to emergency psychiatric facilities, clinics, local community health centers or the state mental hospital.[21]

They concluded that responses from emergency room personnel often exacerbate the domestic violence victim's problems rather than providing her comprehensive medical treatment.[22]

As has been suggested above, physician response is crucial in providing adequate emergency medical care for victims. Survey respondents suggested that, to address the victim's need for adequate emergency medical care, physicians must become more sensitive to the problems of spouse abuse. Training of health professionals working in emergency rooms is necessary to heighten their sensitivity, awareness, and knowledge about the problems faced by victims. This should increase the likelihood of the victim's being properly identified by the emergency room staff when she seeks treatment for her injuries. Respondents also suggested that physicians and other health practitioners must alter their orientation, so as to treat the whole person rather than symptoms only. Finally, respondents said that emergency room personnel need increased knowledge of resources available in the community to assure that appropriate referrals can be made. With this knowledge, the physician, and other emergency room staff, can more confidently confront the woman directly about the nature, prevelance, and history of her abuse and document in her record that battering is the cause of her injuries.[23] It was suggested in the literature that "tagging charts and photographically documenting injuries" might be included in the emergency room response to a spouse abuse problem.[24] It was also suggested that such women should receive a prompt examination so as to "avoid the additional trauma of having to wait in the emergency room immediately after a traumatic crisis situation."[25] Once the woman has received treatment for her injuries, the literature suggests that every effort should be made to protect her from further abuse. This should include exercising extreme caution in prescribing drugs, evaluating whether alternative housing arrangements should be made, admitting the woman to the hospital if necessary, and making appropriate referrals to community resources for counseling, medical followup and temporary shelter if warranted. Another suggestion is that a social worker or ombudsman should be available to emergency room personnel to assist in providing these services.[26]

Need for Ongoing Medical Care

The battered woman also needs ongoing medical care. Victims do not always require emergency care or request medical services for the injuries sustained from battering. They might prefer to request medical attention from a physician or health clinic for

[17] Ibid.
[18] Ibid., p. 468.
[19] Ibid.
[20] Ibid., p. 469.
[21] Ibid.
[22] Ibid., pp 474–77.
[23] Denver Monograph, p. 212.
[24] Ibid., p. 127.
[25] State of New Jersey, Department of Human Services, Divison of Youth and Family Services, "Physically Abused Women and Their Families: The Need for Community Services" (Trenton, N.J.: June 1, 1978), p. 65.
[26] Denver Mongraph, p. 212.

less observable injuries than those that would necessitate emergency treatment. The literature notes:

> Working in a rural medical center, Elaine Hilberman, a psychiatrist at the University of North Carolina Medical School and her staff have seen many women with psychophysiological ailments that were due to battering. They come in with backaches, headaches, stomach ailments, respiratory problems, eczema or other skin rashes, hypertension and other disorders caused by stress and anxiety.[27]

Often the response from the private physician or health clinic is the same as that given by emergency room personnel. Owing to a lack of knowledge, sensitivity, and awareness of the problems of victims, the physician is not properly equipped to identify the victim and take the appropriate medical steps. In a study by Elaine Hilberman and Kit Munson of women referred by the staff of a rural health clinic for mental health counseling, it was found that half of those referred during a 12-month period had "suffered serious and or repeated physical injury as a result of assault by their husband/cohabitees. The history of marital violence was known to the referring physician in only four of the sixty cases despite the fact that most of these women and their children had received ongoing medical care at the clinic."[28]

Physicians and other health care practitioners providing ongoing medical care to victims require training in the causality and dynamics of spouse abuse to improve their knowledge about the problem and to increase their effectiveness.[29] The physician then can recognize a battered woman seeking medical treatment and more appropriately provide for her needs. These ongoing medical needs include a thorough medical workup, an evaluation and assessment of the secondary health problems caused by the battering, treatment for related medical problems, referral for mental health counseling and family planning, if necessary, and a full medical evaluation of any children involved. Respondents in the needs assessment also suggested that universities and professional schools should be involved in educating future health professionals in this field.

[27] Walker, *The Battered Woman*, p. 106.
[28] Elaine Hilberman and Kit Munson, "Sixty Battered Women," *Victimology, An International Journal*, vol. 2, nos. 3 and 4, (1977–78), p. 460.
[29] Denver Monograph, p. 213.
[30] 42 U.S.C.A. §254C (Supp. 1974–79).
[31] U.S., Department of Health, Education, and Welfare, Public Health Service, Health Services Administration, *Program Guidance Material, Health Care Initiatives* (April 1978).

Selected Federal Programs Addressing Health Needs

Core Programs

Community Health Centers

The 1978 Services and Centers Amendments to the Public Health Service Act authorize the community health centers (CHC) program.[30] The CHC program is designed to provide comprehensive health and related social services to medically underserved areas. The "maintenance or improvement of the health of mothers and children is of first priority."[31] The community health centers program is administered by the Bureau of Community Health Services, of the Public Health Service, Department of Health and Human Services. (For detailed information on this program, see appendix B.)

Because the purpose of the community health centers program is to provide comprehensive primary (ambulatory) care to families, it is in an excellent position to address the ongoing health needs of spouse abuse victims, abusers, and their children. CHCs are authorized to provide the diagnostic, treatment, and referral services rendered by a physician.[32] They must also provide diagnostic, laboratory and radiological services, and "preventive health services," which are defined as "medical social services, nutritional assessment and referral, preventive health education, children's eye and ear examinations, prenatal and postpartum care, prenatal services, well child care including periodic screening, immunizations and voluntary family planning services."[33] Various supplementary health services may be provided by CHCs directly or through referral, according to the assessed needs of the community.[34] Of particular relevance to the spouse abuse victim in the supplementary category are mental health services; public health services defined as including services for the "social and other nonmedical needs which affect health status, counselling referral for assistance and follow-up services";[35] and bilingual services.[36] The focus of CHCs is on family health maintenance, and medical staff are

[32] 42 C.F.R. §51c.102(h)(1) & (2) (1979).
[33] *Id.*, §51c.102(h)(2) & (3).
[34] *Id.*, §51c.102(j)(1)–14).
[35] 42 U.S.C.A. §254c(b)(2)(J) (Supp. 1974–79).
[36] 42 C.F.R. §51c.102(j)(14)(1979).

required to assess all the patient's health needs and develop a comprehensive medical plan to address these needs through CHCs and other appropriate health resources.[37] In so doing, CHC staff are in a position to identify both high-risk and abused women who may be receiving center services for problems other than those directly attributed to abuse.

CHCs can provide outpatient medical treatment for injuries, as well as an indepth physicial examination to determine if a woman has developed secondary medical problems as a result of battering. As suggested in the needs assessment, these services are crucial because battered women often neglect their health needs, are at risk for other medical problems because of the stress related to their being battered, and because of the secondary medical and psychiatric effects of battering, such as alcohol, drug addiction, suicide, and psychosomatic illnesses.

Because CHCs may provide medically related social services as well as mental health services, they are in a position also to assess the mental health needs of the victim and make referrals where appropriate. In fiscal year 1980, out of recognition that individuals with mental health problems are often treated within the primary care context, $1.588 million in the CHC budget is earmarked to provide staff persons at approximately 100 CHCs who identify and refer persons in need to local community mental health centers.[38] According to the legislation, CHCs may also contract for supplmental services, such as mental health services,[39] and shelters are not barred from such contracts. However, the general policy of the Bureau of Community Health is to encourage "capacity building," that is, the development of inhouse services. Generally, contracting occurs only for those specialized services that the center or other Bureau programs cannot provide directly.[40] Counseling for abused women, due to the requirement for such specialized skills and training, can be considered such a specialized service.

CHC also may provide a wide range of child health services. This service is important, as documented in the needs assessment, because the health needs of children in violent homes are often neglected.

CHCs can work in various ways with organizations serving battered women to meet their health needs. For example, through informal linkages, centers can make physicians or public health nurses regularly available to shelters to provide physical examinations to the women and their children, to conduct health screening, to provide ongoing medical treatment, and to offer nutrition and health care instruction. Center staff would be appropriate members of multidisciplinary teams designed to address the needs of violent families or of emergency teams responding to spouse abuse crises.

Although emergency services are one of the primary services that centers must provide, their emergency services are generally not comprehensive.[41] Rather, centers treat emergency cases that do not require "specialized personnel and equipment" and arrange for treatment of more serious cases at hospital emergency rooms.[42] Abused women who are treated for medical emergencies at community health centers are likely to encounter the problems cited in the needs assessment. These include the failure of medical staff to recognize the connection between the immediate problem and battering, a reluctance of staff to become involved in the problem even if it is recognized, and the resultant lack of appropriate referral and followup services.

The Bureau of Community Health Services has not established the health needs of battered women as a priority and, therefore, has not required community health centers to collect data to help define the need for service.[43] Although community health centers are required to perform periodic needs assessments, unless center staff recognize spouse abuse as a health problem, they will continue to fail to identify it in their assessments. The Bureau has a policy of targeting groups identified as "at risk" of specific health problems and requires that appropriate data be collected on those groups. An example of such a target group is pregnant adolescents. No such

[37] Phillip William, Deputy Director, Division of Policy Development, Bureau of Community Health Services, telephone interview, Jan. 1, 1980 (hereafter cited as William Interview).
[38] John Covington, public health analyst, Clinical Policies Branch, Office of Community Health Centers, BCHS, telephone interview, Feb. 26, 1980.
[39] 42 U.S.C.A. §254c(b)(2)(E) (Supp. 1974–79).
[40] William Interview.
[41] Ibid.
[42] HEW, *Program Guidance Material*, pp. 12 and 16.
[43] William Interview.

policy, however, has been established for battered wives.[44]

The legislation authorizes the use of Federal grant money for training CHC staff in the services they provide.[45] This money could be used for training staff to understand the complexities of the battering problem, and to identify high-risk cases and actual cases of abuse. Training tools for emergency intervention, evaluation, treatment, referral, and followup could be provided. The Bureau of Community Health Services has not initiated materials or encouraged training on this health problem. Further, no technical assistance has been made available to center staff to assist them in responding to this problem.[46]

Department of Defense

All three branches of the military had started child advocacy programs by 1976. In July 1979 the Navy expanded its child advocacy program by making provision for medical identification, treatment, and followup services for victims of spouse abuse through the family advocacy program (see appendix B). Consistent with the recently approved Defense Department directive on a family advocacy program, the Army is considering a similar expansion by the end of FY 1981.[47] Two local Army installations have developed specialized wife abuse services. The social work clinic, in the Army Social Work Service at Fort Campbell, Kentucky, was able to substantiate the need and obtain formal authorization and support for a battered women's shelter on the post. (See program description, appendix B.)

The spouse abuse committee of McChord Air Force Base, Tacoma, Washington, also was able to develop a program that coordinates treatment, information, referral, and outreach (including public education) for spouse abuse between the military and civilian resources serving McChord Air Force Base personnel and their families. (A more detailed program description has been included in appendix B.)

The Department of the Navy currently operates a program of comprehensive services to Navy and Marine Corps families and individuals in cases of suspected and confirmed spouse abuse, neglect, sexual assault, and rape. Services are provided by the family adovcacy program (FAP), which is an outgrowth of the Navy's Bureau of Medicine and Surgery (BUMED) spouse abuse reporting and child advocacy program.

The Central Child Abuse and Neglect Registry was transformed into the Family Advocacy Central Registry and now records all forms of abuse and neglect, including spouse abuse. Four pilot programs were established to test the merits of the comprehensive family advocacy program. In response to the favorable findings of the FAP pilot projects and further research in the field, BUMED has issued instructions for major medical facilities to implement FAPs. The FAPs are supposed to work with appropriate military and civilian agencies to provide comprehensive services within the larger local military-civilian human services delivery system. FAP also incorporates legal, clinical, and counseling services. (This program is detailed in appendix B.)

Services are available to active duty personnel and their families and retired personnel and their families. Those individuals and families requiring services not provided directly through the military may seek support through civilian agencies[48] within the coverage of the civilian health and medical program of the uniformed services authorized by the Dependents' Medical Care Act of 1956.

Program guidelines cover primary and secondary prevention services. Although FAP provides comprehensive medical and social services for the identification, evaluation, diagnosis, treatment, followup, and reporting of child abuse or neglect, spouse abuse or neglect, and sexual assault cases, administrative and attitudinal barriers appear to interfere with effective implementation. Each naval medical facility is required to designate a social worker or senior member as the family advocacy representative (FAR). When suspected victims of abuse and neglect are seen at naval medical emergency rooms, emergency personnel are required to notify the FAR who "takes appropriate action to

[44] Ibid.
[45] 42 U.S.C.A. §254c (d)(2)(Supp. 1974–79).
[46] William Interview.
[47] Shirley Ann Brown, social work program specialist, Community Support Directorate, Office of Adjutant General, Department of the Army, Washington, D.C., telephone interview, May 11, 1981.
[48] Lt. (jg.) Serge Doucette, Head, family advocacy program, Bureau of Medicine and Surgery, Department of the Navy, interview in Washington, D.C., Dec. 12, 1979 (hereafter cited as Doucette Interview).

evaluate, report and secure treatment for the abuse victim."[49] However, the manual has no guidelines or training provisions for emergency room personnel to help them identify the spouse abuse victim.[50] Without such guidelines, as discussed in the needs assessment, underreporting is assured and treatment limited.

The program's reporting procedures may also be a barrier. The instruction requires that all cases of suspected abuse or neglect be recorded and reported to the family advocacy committee on the base and subsequently to the Central Family Advocacy Committee at the Bureau of Medicine and Surgery, with identifying information to accompany only the confirmed cases.[51] All cases are reviewed by the family advocacy committee, where a determination is made as to whether abuse or neglect has been established, suspected, or ruled out. The commanding officer of the alleged military abuser is notified and sits on the review committee.[52] The involvement of the commanding officer, and the reporting requirements themselves, can discourage victims from seeking help at military facilities owing to concern about the effect on the person's military career. These same fears can limit reporting by military personnel who suspect that battering might be occurring.

An added factor that may affect the reporting and tracking of abuse and neglect cases is that the FAP instruction only applies to military medical facilities.[53] The program does not account for military personnel who live off base and use civilian facilities. Again, the fear of career damage could increase the likelihood that military personnel will use civilian resources where their anonymity can be maintained. The impact of the program is further limited because it applies only to major medical facilities; commands without such facilities are not required to have abuse programs.[54]

Another issue is the family focus of the program. The program instruction states that one guiding principle is the maintenance of the family unit while treatment and support services are being offered.[55] Options provided within the program instruction are limited for those women who want to separate from their military husbands; in fact, the military has little responsibility for them once they do separate. Military benefits, including treatment at medical facilities for the woman are contingent on the status of the marital relationship. Although the separated spouse is eligible for medical services, she is not given priority service at facilities where resources are limited. Once the spouse is divorced, she is not entitled to any further military benefits.[56]

Perhaps the greatest barrier to realizing the potential of the FAP is the level of funding. In essence, the program has expanded child advocacy without providing additional funds or resources, and the Navy initially earmarked very little funding for the child advocacy program. In general, the child advocacy person, normally a social worker at the Navy medical facility, carried this responsibility along with other responsibilities at the hospital. The same principle applies to the family advocate representative. As stated in the instruction, "The success of this program rests upon the ability of evaluating and redirecting current resources in a manner that continues to allow for maximizing medical care to our Navy and Marine Corps members and families."[57] In general, the Navy program relies on existing funds and resources. As of FY 1980, only four FAP programs have been funded under the BUMED instruction.[58]

A program spokesperson at BUMED suggests that without additional funds the program is essentially a paper document.[59] In practical terms, the program currently provides an emergency response at those major medical facilities where it operates for those identified as suspected spouse abuse victims. Beyond this emergency response, the program relies heavily on existing civilian resources.[60]

Veterans Administration Hospitalization and Outpatient Service Programs

The Veterans Administration hospitalization and outpatient services program was established to provide benefits to persons who have served on active military duty. (See detailed description in

[49] U.S., Department of the Navy, Bureau of Medicine and Surgery, Family Advocacy Program Instruction 6320-57, July 11, 1979 (hereafter cited as BUMEDINST 6320-57), p. 25.
[50] Doucette Interview.
[51] BUMEDINST 6320-57, p. 26.
[52] BUMEDINST 6320-57, p. 37.
[53] Doucette Interview.
[54] Ibid.
[55] BUMEDINST 6320-57, p. 36.
[56] Doucette Interview.
[57] BUMEDINST 6320-57, p. 5.
[58] Doucette Interview.
[59] Ibid.
[60] Ibid.

appendix B.) Because of the eligibility requirements, Veterans Administration programs serve a predominantly male population. The population is large (averaging 17 million counseling and outpatient visits a year)[61] and the medical services provided are extensive (172 hospitals)[62] The potential exists within the program to identify and treat spouse abusers and victims as well as to do much of the needed research into the causes of spouse abuse.

Comprehensive inpatient hospital services are offered, including treatment and rehabilitation for alcohol and drug dependence. Outpatient services include readjustment counseling and related services, preventive health care services, and alcohol and drug treatment counseling services. Benefits, with few exceptions, do not include services targeted specifically to the abused spouse or the abuser. However, VA regulations do not prohibit treatment of spouse abusers. For example, a program developed by the Tacoma, Washington, VA Hospital[63] provides nonspecialized outpatient services to spouse abusers. Patients in the Tacoma program are identified through the alcohol and drug abuse program, as well as general medical intake. Special intake and social history protocols have been developed to elicit information leading to the identification of abusers. Patients are also referred to the program by the courts.

The Veterans Administration requires that persons served be veterans or certain specifically designated dependents of veterans,[64] and there is no flexibility in the eligibility requirements. Therefore, except for potential research into abusive behavior, VA programs are limited by virtue of eligibility requirements set by law. (These requirements are enumerated in appendix B.)

Several barriers restrict the Veterans Administration from realizing its legal potential to provide service to spouse abusers and victims. Perhaps the most significant barrier has been the lack of recognition by the VA of spouse abuse as a problem warranting priority attention. As a result, uniform diagnostic procedures for eliciting information from patients, as developed in Tacoma, and leading to identification of abusers are not being used in VA hospitals and outpatient clinics. By establishing such uniform procedures, the VA could produce an important data base for use in research and program development.

Another barrier is posed by the limitations on eligibility for receipt of services by abused wives in the treatment of their abusive husbands. However, precedent exists for the involvement of wives in VA health programs. For example, both husbands and wives are served in the VA's genetic counseling program.

Another very real problem is securing necessary funds for developing new programs. The VA appropriation for FY 80 was less than it was for FY 79.

Since the VA has one of the largest health care networks in the United States, with an impressively large patient population, it has a potentially important role to play in the domestic violence field—especially with respect to research into the male abuser. Such research into the causes, behavior characteristics, and treatment of the abuser is badly needed since stopping abuse means stopping the abuser. Section 4101 of Title 38[65] authorizes research that is likely to contribute to medicine and surgery, as well as to the beneficiaries of VA medical and surgical programs.

The program for abusers in the Tacoma, Washington, VA Hospital is justified, in part, on the research premise that individuals who are involved in family violence seek medical care for ailments other than injuries directly resulting from brutality more frequently than those in nonviolent families. Anne Ganley, who is a codirector of the Tacoma hospital project, found that many of her patients were seeking medical assistance for ailments that were, upon closer scrutiny, masking another problem—wife abuse.[66] Additional research is needed to substantiate Ganley's findings. Further research into the prevention and treatment of spouse abuse has potential advantages for service providers and their patients.

[61] William Sawchak, public information specialist, Public Information Office, Veterans Administration Central Office, interview in Washington, D.C., Nov. 27, 1979.
[62] Ibid.
[63] Anne Ganley, Veterans Administration Hospital, Takoma, Wash., telephone interview, Nov. 28, 1979 (hereafter cited as Ganley Interview).
[64] Ibid.
[65] 38 U.S.C. §4101(c)(1)(1976).
[66] Ganley Interview.

Other Relevant Programs

Public Health Service (PHS) Formula Grants, PHS Act, (Title III, and 314(d) As Amended; 42 U.S.C. 246 (1974 Supp. 1974–1978))

PHS formula grants are provided to States to assist them in meeting the costs of comprehensive public health services. States use these grants in a variety of ways. Services provided under the program that may be of help to the victims of spouse abuse are nursing services, gynecology clinics, and family planning services. Funds may be used with some degree of flexibility to support new approaches to health services delivery, as well as to develop new services, including dental and medical clinics. The Public Health Service clinic in a local community may play an important role in the identification, treatment, and referral of spouse abuse victims.

Migrant Health Grants (PHS Act, Title III, and 329, 42 U.S.C. A §2546b(Supp. 1974–1978)

The purpose of the migrant health program is to support the development and operation of inpatient, supplemental, and environmental health services provided through migrant health centers. Services may include those aimed at both identification and treatment, and, specifically, counseling of parents and their children.

Maternal and Child Health Services DHHS (Public Law 74–271, Title V and 503, 42 U.S.C. §§307–716 (1976)

The maternal and child health services (MCHS) program provides support to States for extension of services into rural and severely economically distressed areas to reduce infant mortality and improve health care of mothers and their children. The MCHS mandate also includes reduction of birth defects and mental retardation through the provision of health care services and information to mothers and children, especially in low-income areas.

The MCHS program could play a significant role in the identification, referral, and treatment of family violence victims. Since this service is often found in underserved and rural areas, its importance as a primary service provided in these areas should not be overlooked.

Indian Health Services (Public Law 83–568 2001–2005f (1976))

The Indian Health Service provides health care to American Indians and Alaskan Natives. A full range of preventive and rehabilitative health services is provided, including public health nursing, maternal and child health care, dental and nutritional services, psychiatric care, and health education. All these services have the potential for serving eligible spouse abuse victims through identification, treatment, and referral.

Family Planning Projects (PHS Act as amended) 42 U.S.C.A. §§300–300a–8 (Supp. 1974–1978)

According to research literature victims of spouse abuse frequently turn to family planning clinics for help. Accordingly, family planning clinics could play an important role in the identification and referral of spouse abuse victims to appropriate services. The purpose of family planning projects is to provide advice and service to men and women on contraception, including natural family planning methods, counseling, physical examinations, diagnostic and treatment services for infertility, contraception supplies, and ongoing medical and periodic followup examinations. Priority is placed on the delivery of services to low-income people.

Chapter 8

Employment and Training

Assessment of Employment, Training, and Education Needs

The findings of the needs assessment and literature review clearly indicate that employment as well as the education and training required to locate and maintain it are major needs of victims of spouse abuse. Without financial independence, battered women have no alternative but to remain in their abusive situations. As Del Martin states: "Many battered women remain in violent domestic situations because they are totally dependent financially on their husbands."[1]

A woman who has been a homemaker and mother for many years may not have had the opportunity to be in the job market or to be trained for employment outside the home. In addition, because of the abuse she has received, she may have low self-esteem, feelings of helplessness, and lack the motivation necessary to pursue employment opportunities aggressively. Judge Lisa Richette, speaking before the Civil Rights Commission, has suggested that women should be compensated for the work they do at home by providing them with training and opportunities to enter the job market.[2] Furthermore, Judge Richette stated that educational and employment opportunities must be adaptable to the dual role of homemaker and family provider. Lenore Walker, in a monograph on services to battered women, points out: "Traditionally, women have been denied equal access to well-paying jobs with fringe benefits due to sex role stereotyping and the burdens of child care."[3]

Walker summarizes some of the unique problems faced by battered women who are seeking employment:

(1) Women who have not been employed for some time may require job training, and/or an improvement in self-concept before they can reenter the job market;

(2) Women who become employed when they enter a shelter may have to quit their jobs because batterers can easily locate them at their place of work; and

(3) A "labeling" process may occur in cases in which employers know that their employees are battered. The consequences of labeling battered female employees in job situations needs to be studied.[4]

In examining the area of employment, training, and education for victims of violence, several specific needs were identified in the assessment and in the literature. These include:

- The provision of prevocational programs;
- The availability of services to develop a realistic employment plan;

[1] Del Martin, *Battered Wives* (San Francisco: Glide Publications, 1976), p. 130.

[2] U.S., Commission on Civil Rights, *Battered Women: Issues of Public Policy*, (consultation sponsored by Commission, Washington, D.C., Jan. 30–31, 1978, p. 130.

[3] U.S., Department of Health, Education, and Welfare, Office of Human Development Services, publication no. 78, Dec. 27, 1978, "A Monograph on Services to Battered Women," (originally published by the Colorado Association for Aid to Battered Women) (hereafter cited as Denver monograph) p. 30.

[4] Ibid., part I, p. 20.

- The provision of day care; and
- The need to establish linkages between spouse abuse programs and community employment resources.

Provision of Prevocational Programs

Before a battered woman is ready to (re)enter the outside world of work, she must be properly prepared for seeking a job or training. Because of her involvement in an abusive relationship, and the potentially resulting image of low self-worth, attitude changes must be made for the job search to be successful. Shelters, which offer peer group support in a "sheltered" environment, are most appropriate to address this prerequisite need. How to apply for a job, fill out applications, and what to expect at the job interview are all prevocational issues.

Development of Individual Employment Plans

Once a woman's prevocational needs are met, she should be ready to examine her training or educational needs. Professional or vocational training and financial assistance to obtain such training are needed, as well as basic skill development and self-education, such as parenting education and assertiveness training. As Lenore Walker points out: "Learning to enjoy all educational and vocational activities is important for women who have been isolated in their violent homes."[5]

Counseling of women toward realistic employment objectives is a major need for battered women. Counseling may be available through various publicly supported programs and may also be provided through women's shelters. The end result of the counseling should be an employment plan. The plan should identify the employment objective and the steps necessary to achieve it. All training and education prescribed should be designed to secure a job that allows for economic independence and a feeling of self-worth.

Job placement services following training or education were also cited by respondents as a priority need. Among these needs are convenient locations of employment opportunities and followup support services.

Societal attitudes toward women also have a major effect on their earning power. Terry Fromson, in "The Case for Legal Remedies for Abused Women," cites a 1976 study by the Women's Bureau of the U.S. Department of Labor that documents the wide disparity in the earning potential of men and women.

> . . .Based. . .on 1974 figures, the study found that women who worked at year-round, full-time jobs earned only 57 cents for every dollar earned by men, that men's median weekly earnings exceeded women's by about $97 and that women had to work nearly nine days to gross the same earnings which men grossed in five days. These discrepancies are partially explained by historical stereotypes that cause women to be placed in lower paying occupations and lower status jobs. Statistics show that women are paid less than men in the same high skill jobs. For instance, the median salaries of women scientists in 1970 were from $1700 to $5100 less than those of men in the same fields. Women are also paid less than men with the same educational background. In 1974, women with four years of college earned only 59 percent of the income of men with four years of college, and had lower incomes than men who only completed the eighth grade. The earning potential of women is further affected by lack of work experience and discontinuous patterns of employment due to absences for childbearing and family responsibilities or difficulty in finding a job.[6]

Provision of Day Care

The extended family, which has traditionally provided care for children of working mothers, is often not available to the abused woman. This is particularly true when the woman's family disagrees with her decision to leave home. Also, because the victim often must move away from her home community to avoid continued abuse, she cannot depend on neighbors or friends to supply the needed day care support. Her lack of financial resources to pay for the escalating cost of child care is also a problem.

Fleming, in *Stopping Wife Abuse,* states that "some shelters see child care as a priority and have instituted a variety of means to provide it. Frequently, volunteers provide this service. Some programs have obtained slots in local day-care programs."[7] Despite these efforts, there remains a need for comprehensive preschool and afterschool day care service for women when they leave the shelter. Various day care options must be available, including infant day care and preschool and extended day

[5] Ibid., part I, p. 17.

[6] Fromson, "The Case for Legal Remedies for Abused Women," 6 N.Y.U. Rev. L. and Soc. Change 135, 139 (1977).

[7] Jennifer Baker Fleming, *Stopping Wife Abuse* (Garden City, N.Y.: Anchor Press/Doubleday, 1979), p. 375.

programs for school-age children, for women entering training or employment programs.

Development of Linkages with Community Resources

To implement an employment plan successfully, a wide array of community-based, employment-related programs must be brought together. The local State employment security office provides job placement for the unemployed; the prime sponsor of the Comprehensive Employment and Training Act (CETA) program has a range of training and job placement services; adult education programs are usually available through public schools and local community colleges and universities; and for low-income and disabled women, the Title XX,[8] vocational rehabilitation,[9] and WIN[10] programs are also available. Cutting through this maze of agencies to construct a rational training and employment plan may be the most difficult task encountered in helping women seeking work. Needs assessment respondents continually pointed to this area as a major need of victims of violence.

Lenore Walker has provided a series of necessary steps for examining the potential available within existing community-based employment resources. These include:

- Exploring the local State employment service;
- Identifying and creating liaisons with women's advocacy and employment groups in the community;
- Contacting the Women's Bureau's Regional Offices within the Department of Labor;
- Ascertaining services available through local service organizations;
- Becoming a politically viable group within the community so as to obtain priority status for selective programs;
- Investigating programs offered by local 2-year community colleges and 4-year colleges and universities;
- Investigating the opportunity to incorporate women into construction and apprenticeship programs; and
- Contacting the local Vocational and Rehabilitation Service—to remind them of their responsibility for serving the disability inherent in battered women.[11]

Selected Federal Programs Addressing Employment, Education, and Training Needs

Core Program

The Comprehensive Employment and Training Act (CETA) of 1973, as amended,[12] decentralized employment and training programs from the Federal Government to the States and local jurisdictions.[13] The principal aim of the act is "to provide job training and employment opportunities for economically disadvantaged, unemployed, and underemployed persons" to enable them to secure self-sustaining, unsubsidized employment.[14] "Prime sponsors" are responsible for assessing local needs and developing programs to meet them through a range of services that can include classroom instruction, on-the-job development, child care, and other support.[15] Prime sponsors, State and local governments, can arrange to provide these services directly or through contracts or subgrants with organizations such as the State employment service, vocational education agencies, community groups, and private firms.[16] (See appendix B for details on CETA.) Some shelters may be eligible to obtain contracts for this purpose.

Portions of Title II[17] and Title VI[18] of the act authorize a subsidized public service employment program, with comprehensive CETA services for participants. The funding level for these efforts was reduced dramatically in FY 1980. Whereas 750,000 enrollees were reported by these programs in FY 1978, the enrollment levels were reduced to 450,000 by the end of FY 1980.[19] It will be even more difficult for women desirous of leaving abusive settings to obtain Title II and VI support in the future.

One-third of the public service employment slots must be in nonprofit and community organizations.

[8] 42 U.S.C.A. §1397–1397f (Supp. 1980).
[9] 29 U.S.C.A. §§701–796i (1976 and Supp. III 1980).
[10] 42 U.S.C. §§630–644 (1976).
[11] Denver Monograph, pp. 16–17.
[12] 29 U.S.C. §§801–999 (Supp. III 1979).
[13] U.S., Department of Labor, *Annual Report of FY 1978*, section Z, program performance, p. 30.
[14] 29 U.S.C.A. §801 (Supp. III 1979).
[15] 20 C.F.R. §676.22, .25–1—.25–5 (1980).
[16] 29 U.S.C.A. §811(d), 813(a)(7) (Supp. III 1979).
[17] *Id.*, §§841–59.
[18] *Id.*, §§961–70.
[19] Hugh Davies, Chief, Division of Program Planning and Design, ETA/DOL, interview in Washington, D.C., Dec. 7, 1979 (hereafter cited as Davies Interview).

The "projects" are limited to 18 months, but can be extended another 18 months by the prime sponsor with whom the purchase-of-service contract is written. Local nonprofit agencies providing services for victims of domestic violence are eligible to apply for these "project" contracts to obtain staffing support.[20] These projects must fall within the 12 categories of emphasis (e.g., community service), and although "battered women" is not currently a designated category, it can be fitted into an existing one. For this to happen, the prime sponsor must convince the local or State CETA board that the needs of battered women constitute a major community need; the specific needs of this group can then be included in the CETA prime sponsor plan.

Title III[21] of the act authorizes the Secretary of Labor to provide services to segments of the population that are disadvantaged in the labor market. The 1978 amendments to the act list groups such as "women," "single parents," "displaced homemakers," "individuals who lack educational credentials," and "public assistance recipients."[22] Three million dollars in Title III discretionary grants was awarded to 31 prime sponsors in FY 80 to provide services to these groups; in addition, $1.25 million was provided nationally to private nonprofit local groups.[23] Some of these funds might have aided women who were battered and who were also "displaced homemakers"; however, since the Department of Labor currently does not collect data on victims of domestic violence, there is no way of determining the degree to which this effort reached the abused woman.

Other Relevant Programs

Community Action Agencies (CAA)

Community action agencies[24] are designed to address the broad scope of needs of income-eligible persons. The CAA is expected to do much toward integrating existing services and providing funding support for those needed services that are not available. Therefore, any employment services could be provided by the CAA, if deemed necessary. Advocacy on behalf of the needs and rights of low-income persons is another major activity of the CAA. (Further information on the CAAs can be found in appendix B.)

Title XX of the Social Security Act

Title XX[25] also has great flexibility in providing a wide range of services for income-eligible persons. Employment services may be provided if they are a part of an approved casework plan and if they are within the budget allotted for the annual State comprehensive administrative and service plan. Training of shelter workers and staff to provide or receive prevocational training would be an example of an activity under this program.

U.S. Employment Service

The U.S. Employment Service[26] through its State and local offices is the major Federal agency providing job placement for the underemployed and the unemployed. Unemployment over a period of time is a prerequisite to receiving service. Since the program was created primarily as a service to employers, potential employees cannot expect their needs to be treated as a priority over the needs of employers. This has resulted in what respondents viewed as a lack of sensitivity to the needs of battered women by Employment Service staff.

Work Incentive Program (WIN)

The WIN[27] program provides training for persons on financial assistance programs as a means of allowing them to become economically independent. Respondents expressed concern that some training programs were not relevant to available jobs, which made it difficult to obtain placement at the conclusion of the program. Low income is a criterion for eligibility.

[20] 20 C.F.R. §678.3(d),(e)(1980).
[21] 29 U.S.C. §§871-86 (Supp. III 1979).
[22] *Id.*, §871(a)(1).
[23] Davies Interview.
[24] 42 U.S.C. §§2781-2837 (1976 & Supp. III 1979).
[25] 42 U.S.C.A. §§1397-1397f (Supp. 1980).
[26] 39 U.S.C. §49.
[27] 42 U.S.C. §§630-644 (1976).

Chapter 9

Organizational Development and Management

Assessment of Organizational Needs

Needs assessment respondents said that community organizations and shelters providing services to victims of spouse abuse have organizational needs at two levels. The first level is internal, the need to plan an entity's program. To plan effectively, programs must develop resources, establish a rational planning process, develop technical skills of staff, and provide for adequate and competent staffing. The second level is external, the need to coordinate services with other organizations and to participate in statewide and national advocacy.

Program Planning Needs

Resource Development

A major need often discussed by respondents is that of obtaining a continuing, long-term source of funding once initial seed money has been used. The draft "A Monograph on Services to Battered Women," points out that "obtaining needed resources and services from existing agencies and institutions is undoubtedly a costly effort in terms of both money and staff energy."[1] Katherine Saltzman of the York Street Center in Denver suggests that "the tendency of many programs has been to try to convince the original funding agency to continue to pick up the program funding on an ongoing basis. Many projects have felt that they were in a revolving door being sent from the public to the private sector and back agai. "[2] She goes on to say that this problem is compounded by the fact that "many project directors have had little or no experience in developing programs or funding bases for programs. As a result, many hit-and-miss approaches have been tried, resulting in little or no success. Some projects open and close regularly, resulting in confusion, low staff morale, and further loss of resources."[3] Some projects have been sucessful in obtaining donated capital equipment, such as furniture and typewriters, from community agencies. Yet, the need for capital equipment is still paramount for most local programs.

Although several programs have managed to maintain their level of services, most of the program staff called in the telephone survey indicated a desire to expand their services, especially those for children. Respondents cited the lack of funds as the greatest barrier to expansion.

The second most frequently cited barrier to developing resources was the complexity of the funding process. Government agencies have not provided the technical assistance needed for small programs to apply for funding.

[1] Colorado Association for Aid to Battered Women, "A Monograph on Services to Battered Women" (draft, December 1978), sec. 1, p. 18 (hereafter cited as Denver Monograph).

[2] Katherine Saltzman, "Family Violence Services" (position paper by the director of York Street Center, Denver, Colo.) (hereafter cited as Saltzman position paper).

[3] Ibid.

The lack of familiarity with, and access to, funding sources is compounded by the political nature of obtaining public funds. Respondents report that most public officials are not attuned to the needs of battered women. Maria Roy states: "It is important for groups interested in helping battered women to make their government accountable for the needs of battered women and to work side-by-side with their representatives in planning and implementing programs."[4]

Private foundations have also been reported as being unresponsive to the needs of local agencies serving battered wives. Del Martin quotes Mary Jean Tully's analysis of the role of foundations: "Too many foundation programs are designed to provide non-controversial solutions to non-controversial problems." Del Martin goes on to say that "most foundation officials are overly cautious and dedicated to the preservation and perpetuation of the status quo."[5]

According to the respondents, a third barrier to expanded services is staffing. Respondents often cited needs for more personnel, as well as for training programs that increase staff competency and improve staff morale. The Denver Monograph summarizes this need:

> The burnout [inability to function well due to emotional and physical fatigue] rate for those working with battered women is high. It is a rare person who can make it beyond three years in any shelter job, and burnout probably occurs after only one to two years for battered women helpers. Therefore, there is a need for mutual support among service providers in this field. Also, staff need to recognize the limits of what they can do within their program, and budget their time proportionately. Many staff people are currently working 60- and 80-hour weeks. Not only is this exhausting to them, but it also establishes a poor role model for clients. The model that should be presented to battered women is that of women valuing themselves.[6]

Turnover of staff, especially project directors, has a negative effect on the programs. Katherine Saltzman states: "Only one or two programs have had the continuous leadership necessary to develop sound policies based on experience."[7] She goes on to say: "Project personnel tend to be underpaid and overworked; many have no school or field experience in clinical work; and, of course, there is little or no job security. As a result, staff turnover tends to be high in most projects and might be higher if the job market were less limited."[8]

Staff training needs were high on the list of respondents. Training is required in several areas, including program planning and technical skills development.

Establishment of a Rational Program Planning Process

Some respondents commented on the difficulty program staff have in establishing proper goals and then implementing them. Fleming points out that ongoing planning is essential to the effectiveness of the organization: "Often, women who have organized support services for battered women found it necessary to begin providing services long before they had originally anticipated, due to the demand."[9] Fleming cites Lynch and Norris: "In many spouse abuse programs there is no lead time for substantive pre-planning. Program goals, structure, and process seem to evolve in response to the often fickle and contradictory demands of external decision-makers who control the resources."[10]

Technical Skills Development

Several respondents cited the need for improving the technical skills of staff. Financial management, for example, was cited as an area requiring skills that many shelter staff lacked. Fund-raising techniques, real estate, and building maintenance were other areas cited as requiring specialized knowledge and expertise. Because of limited budgets, respondents noted, shelters often cannot purchase the skills they need. One respondent suggested that a greater sharing of information should occur within the national shelter movement, particularly in the area of management and administration, where more experienced shelters could be of great assistance to those that are just beginning.

[4] Maria Roy, "Model for Services," in *Battered Women, A Psychological Study of Domestic Violence*, ed. Maria Roy (New York: Van Nostrand Rheinhold, 1977), p. 296.
[5] Del Martin, *Battered Wives* (San Francisco: Glide Publications, 1976), p. 246.
[6] Denver Monograph, part 2, p. 8.
[7] Saltzman position paper.
[8] Ibid.
[9] Jennifer Baker Fleming, *Stopping Wife Abuse* (Garden City, N.Y.: Anchor Press/Doubleday, 1979), pp. 406–07 (hereafter cited as Fleming, *Stopping Wife Abuse*).
[10] Ibid.

Community Coordination and Advocacy

Community Coordination

The need for improved coordination among agencies serving victims and abusers at the community level was often mentioned. Lenore Walker, in the draft monograph, states:

> While many new shelter programs offer comphrensive and innovative services, they typically cannot meet all the local needs of battered women. For this they are dependent upon the police, the courts, hospitals, social service agencies and Federal programs for housing, financial assistance, employment, etc. There is, thus, a need for the coordination of new programs with the existing local services. Without such coordination, necessary community referral systems and procedures are difficult to develop.[11]

To provide effective community coordination, a forum must be established, and leadership provided, to initiate the linking of existing community resources into a comprehensive network. Respondents pointed out that a centralized system for sharing information on resources available for battered women within each community is needed. Del Martin gives an example of such a community coordination effort:

> In a Minneapolis workshop on battered women held in February 1975 and instigated by Women's Advocates, social-worker participants decided to form a consortium to address the problem of coordinating social services. They realized that different people and professions perceive the problem of battered women differently, and that each view, while it may have some validity, is incomplete by itself. The stated purpose of the consortium is to encourage various agencies and professions to interrelate and coordinate their approaches to the complex problems of battered wives.[12]

Another reason for establishing local coordination efforts is to provide advocates for domestic violence victims with local contacts and information on existing service laws and regulations so they can better assist clients in obtaining necessary services. Lenore Walker, in the draft monograph, points out that advocates for domestic violence victims must:

> identify other empathetic individuals within a given system for the purpose of assisting the client in receiving appropriate services. A first step is to know the regulations pertaining to the use of existing services; secondly, to identify rules, regulations, and practices that are hindering and/or preventing battered women from receiving adequate services and thirdly, to identify effective mechanisms for changing the underlying attitudes that affect services to battered women.[13]

Community Awareness/Education

Respondents stressed the importance of bringing to the community's attention the extent of the local problem of spouse abuse. Although some shelter staff have taken responsibility for such community awareness, they often do not have the time individually to conduct a broad-based community awareness program. This requires the concerted effort of people representing various service organizations and interest groups. Fleming suggests that:

> It is particularly important to reach persons who work with abuse victims, such as mental health professionals, emergency-room employees, lawyers and law-enforcement personnel, all of whom may have difficulty understanding and dealing with the problem. As more and more battered women come out of the closet, those within traditional agencies and institutions will need to acquire the skills, understanding, and techniques that are most conducive to developing the independence of the abuse victim.[14]

Respondents also expressed the need for a national media campaign that would increase the general public's understanding of the extent and seriousness of the problem nationwide.

Statewide and National Advocacy

Respondents clearly saw the need for program staff to become more involved in State and national advocacy efforts that address spouse abuse problems. The importance of forming statewide coalitions and task forces to influence State legislative reform and to lobby for additional funding support was stressed. Although shelters and other grassroots local organizations have been advocating for victims at the community level, respondents emphasized that a broader scope of political activity is essential to increase national recognition of the problem and to mobilize the necessary legislative support to address unmet needs.

In testimony before the Civil Rights Commission on statutory reform, Judge Golden Johnson stated the need for legislative action:

> . . .I would have to say that, yes, there are laws on the books available for the use of battered women, but I

[11] Denver Monograph, part I, p. 18.
[12] Martin, *Battered Wives*, p. 123.
[13] Denver Monograph, part II, p. 20.
[14] Fleming, *Stopping Wife Abuse*, pp. 396–97.

suggest that these statutes are not adequate. We need to have laws that are more specifically addressed to the particular problem, or at least the implementation and enforcement of those laws that have been designed to protect battered wives as a specific kind of victim. We need more supportive services; we need more education as to the problem surrounding this particular matter. We need to convince our legislative and law enforcement officials that we are serious in our endeavors to address and eradicate this abusive problem that occurs within a very large segment of our society. . . .[15]

Telephone consultations with members of State and national task forces indicated that such advocacy efforts are progessing, despite the problems that often inhibit State and national coalition building. Transportation costs, for example, are a significant barrier to organizing at the national level. The costs of bringing together State or regional coordinators currently must be borne by the individuals themselves, if local program budgets cannot provide such support. Task force members and coordinators operating at the State or national level usually are the same people who also operate local programs, which limits their time available for national efforts. Respondents suggested that national offices and paid staff are needed to conduct national task force functions and strengthen the national advocacy movement; however, they pointed out that funding for this type of effort is not currently available.

Selected Federal Programs Addressing Organizational Needs

Core Programs

Donated Surplus Personal Property Program

The Federal surplus personal property program authorizes the General Services Administration (GSA) to transfer Federal surplus personal property to the States for donation to public agencies and certain defined private, nonprofit institutions or organizations.[16] The program is a potential resource for organizations and shelters requiring equipment to operate their programs or services. The types of equipment made available under the program include items such as office machines, office supplies, furniture, household goods, and cafeteria equipment.[17] Eligible organizations may request specific items of needed property. The GSA is then required to give consideration to these requests in making their allocations of property to the States. (See appendix B for a more detailed explanation of the program.)

The private, nonprofit institutions and organizations eligible to receive property must provide educational or public health services.[18] This raises a potential barrier to many organizations and shelters serving victims of domestic violence. The GSA defines educational institutions as "approved, accredited, licensed facilities conducting educational programs, such as child care centers, schools for the mentally retarded, and schools for the physically handicapped."[19] This eligibility requirement eliminates those shelters that do not provide one of the programs within the eligiblity definition.

Public health institutions and organizations are defined as programs to promote, maintain, and conserve the public's health by providing health services to individuals and by conducting research, investigations, examinations, training, and demonstrations.[20] An example of an eligible public health service is a maternal and child health program. Organizations and shelters serving victims of spouse abuse are more apt to obtain eligibility under this definition. Agencies providing services to victims of spouse abuse may qualify as public health service providers, thus qualifying for receipt of donated personal property. For example, GSA staff responsible for the administration of the program indicated that one application of a woman's shelter program had been denied because it did not conform with either the educational or public health service definitions. Yet, another application by a shelter was being considered because it appeared to meet the public health service definition and also because the shelter was receiving other public funds.[21]

[15] Judge Golden Johnson, testimony, *Battered Women: Issues of Public Policy* (a consultation sponsored by the Commission on Civil Rights, Washington, D.C., Jan. 30–31, 1978), p. 61.
[16] 40 U.S.C. §484(j)(1976).
[17] U.S., General Services Administration, *Federal Surplus Personal Property Donations Program* (1977), p. 1; Raymond Shepard, General Services Administration, telephone interview in Washington, D.C., Nov. 2, 1979 (hereafter cited as Shepard Interview).
[18] 40 U.S.C. §484(j)(3)(B)(1976).
[19] 41 C.F.R. §101–44.207(a)(9)(1979).
[20] 41 C.F.R. §101–44.207(a)(19)(1979).
[21] Shepard Interview.

Volunteers in Service to America (VISTA)

ACTION is the agency designated to administer all programs authorized under the Domestic Volunteer Services Act of 1973.[23] All programs provide potential resources to assist in meeting the needs of organizations and shelters serving victims of domestic violence. Programs include volunteers in service to America (VISTA), the foster grandparent Program (FGP), and the retired senior volunteer program (RSVP).

The VISTA program appears to have the greatest potential for providing support to local organizations serving victims and abusers in the areas of advocacy, planning, and community coordination. VISTA provides full-time volunteers to help community-based organizations mobilize community resources for solving poverty-related problems. The emphasis of the program is on increasing the ability of low-income residents of the community to solve their own problems.[23] VISTA volunteers live for a year in an assigned community.[24] A nonprofit agency committed to finding solutions to poverty-related problems may sponsor a VISTA volunteer.

The services of VISTA volunteers can be useful in bringing attention to the problem of spouse abuse and developing methods of encouraging a positive community response to the needs of battered women. Although VISTA volunteers do not perform direct service functions, they can promote community education and awareness of a local problem. Mobilizing such community support and encouraging community groups to work together in developing comprehensive service networks for abused women are examples of the types of activities that could most effectively be conducted by VISTA volunteers.

Two major issues limit the potential usefulness of this program to local organizations serving battered women. The first is the priority assigned to spouse abuse projects within the VISTA program. The second is the value of the volunteer programs as viewed by Congress.

Although the broad program objectives and guidelines are determined at the headquarters level, regional offices have great latitude in determining the needs within their region and assigning priority to them for the assignment of volunteers. In 1979, 49 out of 4,300 VISTA volunteers nationwide were working in domestic violence projects.[25] Special directives on priority-setting are occasionally sent to the regional offices from headquarters. No directive has been sent to the regions advising that spouse abuse be given priority attention.[26]

In FY 1980, VISTA operated under a continuing resolution with an annualized appropriation of $28 million.[27]

Food Donation Program

The food donation program is intended to improve the diets of school children, needy persons in households, persons on Indian reservations who are not participating in the food stamp program, infants and young children, the elderly, pregnant and lactating women, and other individuals needing food assistance.[28] A second objective of the program is to utilize surplus or abundant commodities, whether in private stocks or acquired through the price support operations of the Commodity Credit Corporation before they are disposed of through other means.[29]

The Department of Agriculture administers the food donation program through various State agencies, for example, State departments of education or State welfare agencies.[30] Applications for participation in the program from local agencies are directed to the designated State distributing agency, which has responsibility for determining eligibility. Regional offices of the Department are charged with responsibility for reviewing and monitoring the program as it operates within the States.[31]

Eligible local recipient agencies may include schools, child care institutions, nonprofit summer camps, welfare agencies, disaster relief organizations, nutrition programs for the elderly, and charitable institutions.[32] Charitable institutions are defined as nonpenal, noneducational public institutions; non-

[23] 42 U.S.C. §4951 (1976).

[24] VISTA Handbook No. 4301.1 (7/1/75) p. 1.

[25] VISTA Guidance Papers, Office of the VISTA Director, March 1978, p. 7.

[26] Mimi Majors, ACTION, interview in Washington, D.C., Oct. 30, 1979.

[27] Torrie Mattes, ACTION, interview in Washington, D.C. Oct. 19, 1979 (hereafter cited as Mattes Interview).

[28] 7 C.F.R. §250.1(a)(b); 250.3(j),(k),(m)(1979).

[29] *Id.*

[30] Jennifer Nelson, Acting Deputy Administrator, Special Nutrition Programs, Department of Agriculture, interview in Washington, D.C., Oct. 19, 1979 (hereafter cited as Nelson Interview).

[31] Ibid.

[32] 7 C.F.R. §250.8(1979).

profit, tax-exempt private hospitals; or other nonprofit private institutions organized for charitable or public welfare purposes.[33] They must maintain an established feeding operation on a regular basis as an integral part of their normal activities to qualify for the program.[34]

Individuals eligible to receive donated food include needy persons in households; disaster victims; all children in schools, child care institutions, and summer camps participating in the program; needy persons served by charitable institutions that receive donated food; all elderly persons who participate in nutrition programs receiving donated food; and families living on, or near, an Indian reservation who are certified by the local welfare office as having inadequate income.[35]

Local agencies determined eligible for the program may obtain food items and, in some cases, cash assistance. Food items may include surplus removal foods (e.g., fruits, vegetables, meat, and poultry) or price support foods (e.g., flour, oil, butter, peanut butter, dry milk, and rolled oats).[36]

The food donation program offers a potential opportunity for shelters to save money on one of their most expensive budget items—food. However, a major issue is whether shelters are eligible to participate within the program's definition of "charitable institutions." To do so, they must conduct a regular, nonprofit food service and be able to accept and store large quantities of food. Currently, decisions determining eligiblity are made at the State level by the designated State distributing agency.[37] However, clarification of the qualifications of shelters as charitable institutions must first be provided at the Federal level.

Charitable institutions currently receive price support foods but do not receive the more substantial surplus removal foods.[38] Neither legislation nor regulations currently prohibit charitable institutions from receiving such foods; rather, it is through line item appropriations that only price support foods have been made available to charitable institutions.[39]

Currently, there is no outreach or information dissemination program which ensures that shelters will become aware of the potential support available through this program. The process as it now operates requires a shelter to contact the Agriculture Department or its designated distribution agency to learn about this program.[40]

Other Relevant Programs

Title XX Social Services

The Title XX social services program (as described above) has the potential for meeting the needs of organizations and shelters serving victims of domestic violence as a source of funding for direct services. Title XX services are provided by State agencies, often through purchase of service contracts with local nonprofit agencies, such as shelters. Therefore, any of the services allowable under Title XX could be obtained through contracts with private nonprofit organizations and shelters serving victims of spouse abuse. While Title XX funds cannot be used for the construction or renovation of facilities,[41] it is standard practice in public agency purchase-of-service contracts to pay for all, or at least a portion, of the overhead costs of purchased services. Therefore, at least a portion of the costs of maintaining the physical shelter facilities and equipment should be considered as legitimate components of the overhead costs of a program, eligible for inclusion in the contract request.

Title XX also provides a potential mechanism for the provision of a planning and coordination function to victims of spouse abuse. Since the State Title XX agency is responsible for providing services to a broad range of persons, it is an ideal resource to provide the necessary coordination for comprehensive social service programming. Title XX decisionmakers must recognize the needs of victims and abusers for inclusion of victim and abuser services within the State plan. Contract support can only be made for those services that are included within the approved annual Title XX State plan.

Community Action Programs (CAPs)

Community action programs are a potential means of meeting many of the needs of organizations and shelters serving victims of domestic violence. As indicated in the section on social services, communi-

[33] *Id.*, §250.3(g).
[34] *Id.*, §250.8(b).
[35] *Id.*, §250.8 and .9; also §250.6(e)(i).
[36] *Id.* §250.1 and 4.
[37] Darrel Grey, Director, Food Distribution Division, Special Nutrition Programs, Department of Agriculture, telephone interview on Oct. 25, 1979 (hereafter cited as Grey Interview).
[38] Nelson Interview.
[39] Grey Interview.
[40] Ibid.
[41] 42 U.S.C. §1397a (a)(7)(B)(1977).

ty action agencies (CAAs) have the flexibility to determine the needs of the population in their local area and to plan and implement programs to meet those needs. Any of the program needs of organizations and shelters serving victims of domestic violence could be included. CAA activities could include the acquisition of physical facilities, the renovation of facilities for use by shelters and service organizations, the provision of training and technical assistance to program staff, and the mobilization of ongoing funding for program operation. The CAA is also charged with comprehensive service planning and the coordination of services for low-income persons.[42]

[42] 42 U.S.C. §2824 (1977).

Chapter 10

Specific Federal Initiatives

In addition to the programs examined in the previous chapters, several Federal initiatives on domestic violence were underway during 1979 and 1980. This chapter outlines several of these initiatives, aimed at improving research, coordination, and provision of services to victims of spouse abuse and their families. The outline includes specific projects that were part of these initiatives. Many of these projects were short term in nature while others conceptualized at their inception as ongoing, have since ended. They have been included for historical purposes and for their effect on present and future delivery of services to battered women.

These initiatives included:

- Establishment of the Office on Domestic Violence in the Department of Health and Human Services. The office, described in detail in this chapter, was abolished in January 1981.
- Establishment of the Interdepartmental Committee on Domestic Violence by order of President Carter.
- The development of a draft directive on family violence by the Department of Defense. In May 1981 the directive was approved by Defense officials.
- The development of research efforts on family violence by the National Insitute of Mental Health.

Office On Domestic Violence

The Office on Domestic Violence was established administratively by the Secretary of HEW in May 1979.[1] From its establishment until its end in Janurary 1981, it served as a central focus for policy development, planning, provision of information, and coordination of activities related to domestic violence within HHS. Additionally, the Office was designed to establish and maintain liaison with other Federal agencies and provide staff support for the Interdepartmental Committee on Domestic Violence.

The Office on Domestic Violence was part of the Administration for Children, Youth and Families (ACYF) within the Office of Human Development Services. The Office consisted of five staff persons including a Director who reported directly to the Commissioner of ACYF. In the spring of 1979 the ACYF and the Public Health Service (PHS) were requested by the Secretary of HEW to reserve program funds and to provide staff support for the new office. For FY 1979, $350,000 was reserved from the budget of these two agencies to support the programs of the Office and for FY 1980 this figure was increased to $1.5 million.

The Office on Domestic Violence was abolished in January 1981 with staff and functions transferred to the National Center on Child Abuse and Neglect (NCCAN)[2] Ongoing projects are scheduled to con-

[1] Initial information on the Office on Domestic Violence was obtained from June Zeitlin, Director, Office on Domestic Violence, in an interview Dec. 13, 1979, Washington, D.C.

[2] Zeitlin information was reviewed and updated by Jeannie N. Santos, Special Assistant to the Director, National Center for

tinue through the end of their funding period. Present domestic violence staff in NCCAN will continue to coordinate Federal efforts and serve as a focal point for information and assistance in program development. A major coordination effort of NCCAN staff will be the continuation of the newsletter, "RESPONSE" (described below). Some funds will be available from NCCAN for projects to assist violent families, but they will be limited to projects that address the needs of children, such as projects providing services to children of battered women in shelters.

Scope of the Initiatives

The Office on Domestic Violence was established to support public information, technical assistance, training, research, and demonstration activities related to spouse abuse. Additionally, within DHHS the Office works with other DHHS agencies, such as the National Institute of Mental Health, National Institute of Alcohol Abuse and Alcoholism, and the National Center on Child Abuse and Neglect, to coordinate policy and strengthen each program's capacity to provide services to spouse abuse victims and their families. The Office on Domestic Violence did not provide grants for direct services programs, however, some funding was available for demonstration grants.

For FY 1979 the activities of the Office on Domestic Violence included the following projects, most of which are due to terminate at the end of FY 1981:

1. *National Clearinghouse on Domestic Violence.* The Office on Domestic Violence contracted with an existing clearinghouse operation to develop, collect, and disseminate information on the incidence and causes of spouse abuse as well as related service programs and other relevant information. The clearinghouse is available to community organizations, local, State, and Federal organizations, researchers, and the general public. The address is P.O. Box 2309, Rockville, MD 20852.

2. *Resource Project on Family Violence at the Center for Women Policy Studies, Washington, D.C.* The Office on Domestic Violence joined the Law Enforcement Assistance Administration in 1979 in funding the Center for Women Policy Studies Resource Center on Family Violence. The center had been developing materials and providing technical assistance to organizations in the criminal justice field. New materials were developed on topics such as social services, health, and violence in military families. The resource center helped to educate social service and medical providers' professional organizations, public agencies, and volunteers about program needs and developments in the field.

3. *Response Newsletter.* The Center for Women Policy Studies also received funds from the Office on Domestic Violence in 1980 to expand its monthly newsletter. Along with monthly feature articles on health and social service activities, *Response* includes funding information, State and Federal legislative updates, legal developments, research reports, and literature and film reviews.

4. *Title XX—Resource and Education Project.* The Office on Domestic Violence awarded a grant to the National Coalition Against Domestic Violence to gather data on a State-by-State basis on the use of Title XX funds by programs serving battered women. Barriers to receiving Title XX funds were analyzed. A handbook written to help service providers apply for Title XX funds to serve battered women will be available in summer 1981.

5. *Services to Children.* Through collaboration with the National Center on Child Abuse and Neglect and the Office of Program Research and Evaluation, the Office on Domestic Violence is supporting 1-year demonstration projects aimed at helping the children of abused women. The Harriet Tubman Shelter in Minneapolis, Minnesota, the YWCA in Tacoma, Washington, and the Family Services Association in Knoxville, Tennessee, have received funds for demonstration projects designed to provide services to children of battered women.

In fiscal year 1980 the Office on Domestic Violence concentrated on technical assistance programs, public awareness activities, health training programs, and model advocacy demonstration projects for spouse abuse victims and their families. The following projects were funded in FY 1980.

1. *Funding for 10 Regional Centers.* Ten regional technical assistance centers on family violence and a national center in Ann Arbor, Michigan, were funded by ACTION during fiscal year 1979. Each center was staffed by one paid director and volunteers. The resource centers provided technical assistance directly in the area of domestic violence, developed resources in the community, and served

Child Abuse and Neglect, Department of Health and Human Services, May 5, 1981.

in a coordinating and network capacity. During 1979 conferences were held at each of the centers on topics relevant to service providers. Topics included funding, training volunteers, police training, and developing minority women leadership. Joint funding by ACTION and the Office on Domestic Violence for the 10 regional centers was provided in FY 1980 to continue and expand their networking activities.

Region I: — Domestic Violence Technical Assistance Project
Casa Myrna Vasquez
342 Shawmut Ave.
Boston, MA 02118

Region II: — Volunteers Against Violence Technical Assistance Program
American Friends Service Committee
16 Rutherford Place
New York, NY 10003

Region III: — Domestic Violence Technical Assistance Project
Pennsylvania Coalition Against Domestic Violence
2405 North Front Street
Harrisburg, PA 17110

Region IV: — Domestic Violence Technical Assistance Project
University of Tennessee
Division of Continuing Education
426 Communications Building
Knoxville, TN 37916

Region V: — Technical Assistance Center
Community Crisis Center
600 Margaret Place
Elgin, IL 60120

Region VI: — Technical Assistance Center
Houston Area Women's Center
Council for Abused Women
P.O. Box 20186, Room E-401
Houston, TX 77025

Region VII: — Rural Family Violence Project
2202 South 11th St., Room 455
Lincoln, NB 68502

Region VIII: — Technical Assistance Project
Colorado Association for Aid to Battered Women
Box 136, Colorado Women's College
Montview and Quebec
Denver, CO 80220

Region IX: — Technical Assistance Center
Southern California Coalition on Battered Women
P.O. Box 5036
Santa Monica, CA 90405

Region X: — Washington State Shelter Network
Technical Assistance Office
405 Broadway
Tacoma, WA 98402

2. *Research and Demonstration Grants.* These grants were awarded for development of advocacy projects to help domestic violence victims. The projects would demonstrate various models of advocacy for battered women and tactics for changing the ways in which agencies respond to them.

3. *Development of Materials for Health Care Practitioners.* Materials for nurses, physicians, and emergency room personnel were to be developed to inform them of the extent and the seriousness of the problem, thus aiding in early identification of abused women. These materials include emergency room protocol and training films.

4. *Development of Program Materials for Abusers.* The Office on Domestic Violence collaborated with LEAA to develop program materials concerning the abuser. Three short films have been developed for service providers who counsel the abuser.

5. *Training Materials for Judges and Court Personnel.* This project, supported by the Office of Domestic Violence and LEAA, involved the development of a film and supporting materials to be used in associations of judges and lawyers to increase their understanding of domestic violence and available legal remedies. The materials and film are expected to be available by summer 1981.

Interdepartmental Committee on Domestic Violence

President Carter, on April 27, 1979, asked the Secretary of HEW to establish an Interdepartmental Committee on Domestic Violence to develop a coordinated Federal response to the problem of domestic violence.[3] The Committee was composed of representatives from ACTION, the Community Services Administration, the Legal Services Corporation, and the Departments of Agriculture, Defense, Housing and Urban Development, Justice, Labor, Interior, and Transportation. The President

[3] Memorandum from President Jimmy Carter to agency heads, Apr. 27, 1979.

requested that the Committee review Federal programs that were currently providing, or could be providing, services to domestic violence victims and make recommendations that would strengthen the Federal response to the problem. A policy-level member from each Department was designated and the Chairperson is the Director of the Office on Domestic Violence at HHS.

The task of the Committee was to respond to the President's request to review Federal programs that are currently or could be providing services to domestic violence victims. Questionnaires were sent to staff of each of the agencies represented on the Committee requesting detailed information about agency programs providing services or having the potential to serve victims of domestic violence. The questionnaire also asked for information about funding, services provided, program eligibility requirements, target populations, provisions for technical assistance, training, and research.

The information that the Committee received from Federal agencies served as a basis for the *Federal Resources Handbook for Domestic Violence Programs.* Published in December 1980, the handbook is available through the National Clearinghouse on Domestic Violence, mentioned earlier.

Additionally, the Committee established task forces on Native Americans and on the military because the Federal Government plays a direct role in providing services to these two groups.[4]

Defense Department

During the conduct of this study, the DOD Family Advocacy Committee drafted a directive that would establish a family advocacy program similar to the program already established in the Navy (see appendix B) in each branch of the military. The draft directive outlined Department of Defense policy on family advocacy, assigns responsibility for management and implementation of the program, and describes procedures for "prevention, identification, treatment, evaluation, documentation, medical and nonmedical management, followup and disposition of suspected and established child and spouse maltreatment cases."[5] In May 1981, the final directive was approved and subsequently issued by the Defense Department. The directive results in the expansion of the services child advocacy programs [provide] to encompass spouse abuse and established at the Department of Defense level a coordinated and uniform program effort, which recognizes that programs shall be designed to meet local needs.[6]

The directive developed from a recognition of the link between child and spouse abuse as well as a recognition by the Department of Defense of the need to assume a more active role in family matters.

The predecessor to the DOD Service Family Advocacy Committee, the Tri-Service Child Advocacy Working Group, was established in the Department of Defense in January 1975. At that time, the major responsibility of the Committee was to monitor existing child advocacy programs rather than to establish Department of Defense policy in this area.[7]

The decision by this Committee to broaden its focus to include spouse abuse and to draft a Department of Defense directive establishing family advocacy programs was affected by two factors. First, the Committee became increasingly aware of other forms of violence within the family in addition to child abuse and recognized that child advocacy programs are incomplete without addressing other forms of family violence. This recognition came through the Committee's monitoring and the services' program experiences. Literature in the field corroborated the Committee's recognition of this problem.[8]

Second, the military has slowly been changing with the end of conscription and the changing role of women within society and the military. These changes have necessitated a reassessment of the military's traditional role regarding military families.[9] The family traditionally has been viewed as a

[4] All information on the Interdepartmental Committee on Domestic Violence was obtained from June Zeitlin, Director, Office on Domestic Violence in an interview, Dec. 13, 1979, Washington, D.C.

[5] U.S., Department of Defense, Directive, Assistant Secretary of Defense (Health Affairs), Family Advocacy Program (Draft), Aug. 17, 1979, p. 1 (hereafter cited as DOD Draft Directive).

[6] U.S., Department of Defense, Deputy Secretary of Defense Directive 6400.1, Family Advocacy Program, May 19, 1981 (hereafter cited as DOD Directive).

[7] U.S., General Accounting Office, *Military Child Advocacy Programs—Victims of Neglect,* (HRD 79-75, May 23, 1979), p. 11 (hereafter cited as GAO Report).

[8] Lt. (jg.) Serge Doucette, Head, Family Advocacy Program, Bureau of Medicine and Surgery, Department of the Navy (hereafter cited as Doucette Interviews).

[9] James L. Lacey, Special Assistant to the Assistant Secretary of Defense, Manpower Reserve Affairs and Logistics, interview in Washington, D.C., Nov. 13, 1979.

"passive appendage," not a significant factor affecting military policy.[10] Military families often have to accept forced family relocations, separations, and other hardships because military policy has given family concerns a low priority.[11] Increasingly, however, the services have recognized that the quality of family life affects performance, job satisfaction, and, most important, retention, thereby affecting military capability.

The Department of Defense broadened the focus of the Tri-Service Child Advocacy Working Committee to include spouse abuse and neglect and plans to change its name to the DOD Family Advocacy Committee. The Committee drafted a directive that establishes Department of Defense policy regarding military families and improves the existing child advocacy programs by making them more responsive to families' needs.[12]

The directive, effective upon release, assigns responsibility to the Assistant Secretary of Defense, Health Affairs, for developing a coordinated approach to family advocacy matters and forming a Department of Defense Family Advocacy Committee consisting of the family advocacy program managers from each service.[13] The Coast Guard, as a military service and potential beneficiary and contributor to the family advocacy program shall be invited to designate a program representative.[14] The Committee advises the Assistant Secretary of Defense for Health Affairs, monitors military and civilian developments in the area of family violence, provides necessary liaison with civilian and military resources, and develops and manages a military resource center.[15] In collaboration with the National Center on Child Abuse and Neglect, HHS, the Committee is responsible for establishing a Military Family Resources Center (MFRC), implementing a central reporting system, and developing educational aspects of the family advocacy program.[16]

The directive assigns responsibilities to DOD and Secretaries of each military department for implementing a family advocacy program, including allocation of financial and personnel resources.[17] The program managers would have responsibility for managing and monitoring installation programs as well as coordinating policy with the Department of Defense, and Federal and civilian agencies and resources.[18]

The directive applies to the Office of the Secretary of Defense, all military departments, and all personnel "eligible to receive treatment in military medical treatment facilities."[19] The directive establishes a coordinated family advocacy program for each branch of the military as the appropriate mechanism for prevention, treatment, investigation, and reporting activities.[20] Its provisions may apply to the Coast Guard.[21] Policy on relationships between the military installation and the local civilian community is also defined.

A major policy change is presented in the directive; for the purposes of the directive, all exclusive jurisdiction installations (installations in which military personnel are considered federalized citizens and subject only to military and Federal laws) would be considered concurrent jurisdiction installations in which both State and military laws apply.[22] This policy responds to the GAO report, which pointed out the difficulty that CAPs had in coordinating activities with civilian agencies at installations of exclusive jurisdiction. At these installations, civilian agencies' authority to intervene even when a law had been broken had been challenged.[23]

Center for Studies of Crime and Delinquency, Division of Special Mental Health Programs (NIMH)

The Center for Studies of Crime and Deliquency has been funding research and training grants in the area of spouse abuse since 1968.[24] Initial interest in the area of spouse abuse grew out of the Center's concern for improving police response to potentially

[10] Hamilton I. McCubbin, Martha A. Marsden, Kathleen P. Durning, and Edna J. Hunger, "Family Policy in the Armed Forces, An Assessment," *Air University Review*, vol. XXIX, no. 6 (September–October 1968), pp. 1, 46.

[11] Ibid., p. 47.

[12] Capt. Peter A. Flynn, Medical Corps, U.S. Navy, Special Assistant for Professional Activities, Assistant Secretary of Health Affairs, DOD, interview in Washington, D.C., Dec. 12, 1979.

[13] DOD Directive, p. 2.

[14] Ibid., pp. 2–3.

[15] Ibid., pp. 3–5.

[16] Ibid., p. 3.

[17] Ibid., p. 4.

[18] Ibid., pp. 3–4.

[19] Ibid., p. 1.

[20] Ibid., p. 2.

[21] Ibid., p. 1.

[22] Ibid., p. 2.

[23] GAO Report, p. 12.

[24] Thomas Lalley, Deputy Chief, Center for Studies of Crime and Delinquency, interview at NIMH, Rockville, Md., Dec. 12, 1979 (hereafter cited as Lalley Interview).

volatile domestic disturbance situations. In an effort to test cost-effective police approaches to domestic disturbance calls, the Center first funded a research and training project designed by the Oakland Police Department.[26] The project resulted in a model domestic disturbance program based on the practical experiences of police officers who had demonstrated effective approaches to handling domestic disturbance calls.[26] In the early 1970s the Center funded a research project involving the Minneapolis and St. Paul Police Departments. This study involved the recording and subsequent analysis of police-citizen interactions.[27]

By the early 1970s it became increasingly apparent to NIMH and the research community that a "broader view of family violence" than that reflected by existing child abuse and police response research was needed.[28] To respond to this need, the Center funded a research project on intrafamily violence conducted by Murray Straus, professor at the University of New Hampshire. Through this effort, the first national survey to "determine the nature, incidence and severity of household violence in the US" was conducted by Straus, Richard J. Gelles, and Suzanne K. Steinmetz. This research has provided the impetus for further studies on family violence funded by the Center.[29]

The Center has identified research needs in the following areas: family and societal factors associated with domestic violence, and the response by public and private agencies to violence.[30] In FY 1979 the Center funded four research grants and three training grants and fellowships in the area of family violence.[31]

Organizational Structure

The Center for Studies of Crime and Deliquency is one of seven programs in the Division of Special Mental Health Programs of NIMH. The function of the Division is to fund research and training activities in problems directly related to mental health.

[26] Saleem A. Shah, Ph.D, Chief, Center for Studies of Crime and Delinquency (NIMH), testimony, Hearings Before the Subcomm. on Domestic and International Scientific Planning, Analysis and Cooperation of the House Comm. on Science and Technology, Feb. 14, 1978, p. 2 (hereafter cited as Shaw Testimony).
[26] Ibid.
[27] Lalley Interview.
[28] Shah Testimony. p. 4.

Scope of the Initiative

In fiscal year 1979 the Center was supporting four spouse abuse studies:

"Physical Violence in American Families." This project started in 1975 and will continue to June 1981. Initially the research involved developing and implementing a national survey to determine the incidence of intrafamily violence. Data include incidence of physical violence between family members, including child abuse, wife beating, and husband beating; sibling violence; and violence by children towards parents. Research efforts are now addressed to the relationship between growing up in a violent home and being a violent parent or spouse; the relationship of various factors such as geographic location, socioeconomic status, and race to the incidence of domestic violence; and the relationship between the use of physical violence and balance of power between husband and wife.[33]

"Battered Women Syndrome Study." This research project, funded from July 1978 to June 1980, involves a sample of 400 self-identified battered women. The research seeks to test the theory of "learned helplessness" and to determine "the extent to which battering occurs within a recurrent cycle of events with discreet stages identified as tension-building, battering, and calm, respite stage."[33]

"Medical Contexts and Sequelae of Domestic Violence." This project at New Haven Hospital is studying the medical records of 1,850 women who have been treated for injuries at the emergency room, attempted suicide, or have been involved in child abuse. Goals are to learn more about the physical and mental health contexts in which battering occurs as well as the physical and mental consequences for the battered woman.[34]

"Violent Husbands and Their Wives 'Reactions'." This 2-year project is studying the relationship of wife beating to other forms of individual violence, both domestic and nondomestic.[35]

The Center has also funded two training grants and a fellowship in domestic violence. One grant is being used to equip sociologists with theoretical and

[29] Ibid.
[30] Lalley Interview.
[31] Ibid.
[32] NIMH, Center for Studies of Crime and Delinquency, Bulletin on Active Grants in Domestic Violence, (1977) p. 1.
[33] Ibid.
[34] Ibid., p. 2.
[35] Ibid.

research skills necessary to investigate "the causes and consequences of violence in families."[36] A second supports a 3-year training program to "promote greater coordination between clinical practice and behavioral and social science research in the family violence area." The fellowship supports study of abusive parents and their siblings.[37]

[36] Ibid., p. 3.
[37] Ibid., p. 4.

Funding

For fiscal year 1979 the Center received $4.7 million for research and $1.7 million for training. Of that money, $402,444 went to domestic violence research grants and $224,398 went to domestic violence training grants. In FY 1980 overall funding to the Center was expected to be comparable. It was estimated that $220,000 would go to domestic violence research grants and $250,000 to training grants. Grants are generally for 2 years.[38]

[38] Lalley Interview.

Chapter 11

Legislative Directions in Spouse Abuse

The recent attempts of Federal agencies to develop specific initiatives on behalf of battered women was accompanied by equally new efforts by Congress to introduce domestic violence bills. After a brief attempt to pass legislation in 1978—legislation that passed in the Senate but was not voted on in the House prior to recess—Congress in 1979–80 considered two domestic bills. The House of Representatives passed H.R. 2977,[1] the Domestic Violence Prevention and Services Act, on December 12, 1979, by a vote of 292 to 106.[2] A similar bill, S. 1843,[3] was passed by the Senate.[4] The Conference Report was passed by the House, but, following the national elections in November 1980, was withdrawn from further consideration by its Senate sponsors. In the 97th Congress, the House bill was reintroduced on February 4, 1981, as H.R. 1651 under the same title with similar provisions. No Senate version was introduced as of September 15, 1981.

The "Findings and purpose" sections of both House and Senate bills are virtually the same. The congressional findings, as stated in both bills are:

- There is a significant degree of violence within families;
- The reported incidence of violence is much less than its prevalance;
- Domestic violence presents a major danager to law enforcement personnel responding to requests for assistance;
- Domestic violence affects families from all social and economic backgrounds; and
- The effectiveness of State laws and State and local programs designed to prevent domestic violence or provide assistance to victims is not readily ascertainable.

In response to these findings, the purpose of the bills is to stimulate greater participation by the States, local communities, and private nonprofit organizations in their efforts to prevent domestic violence and to provide emergency shelters and other forms of assistance to victims. Additional purposes of the bills are to provide technical assistance and training to domestic violence service providers, to establish a Federal interagency council to improve coordination of Federal programs related to domestic violence, and to provide information gathering and reporting programs related to domestic violence.

From an examination of the purpose statements of H.R. 1651, H.R. 2977, and S. 1843, as well as the content of the bills, the clear emphasis on these pieces of legislation is on provision of assistance to State and local programs serving victims of domestic violence. Special emphasis is given to organizations providing immediate shelter to victims of domestic violence and dependents of the victims of domestic violence.

[1] H.R. 2977, 96th Cong., 1st sess., 125 Cong. Rec. H1,358 (daily ed. Mar. 14, 1979).
[2] 125 Cong. Rec. H11,877–78 (daily ed. Dec. 12, 1979).
[3] S. 1843, 96th Cong., 1st Sess., 125 Cong. Rec. S13,687 (daily ed. Sept. 28, 1979).
[4] A comparative analysis of the provisions of H.R. 2977 and S. 1843 is found in app. C.

Although the legislative language does not explicitly indicate that the major intent of these bills is to provide primary assistance to adult female victims of domestic violence and (where the circumstances apply) to their children, this intent is made clear in the introduction to S. 1843 and in various stages of debate on the passage of H.R. 2977.

While the most recent pieces of Federal legislation on spouse abuse are certainly a step in the right direction, they are little more than small project grant bills that cannot begin to meet the needs of the hundreds of thousands of women who experience abuse each year. Work on this report suggests several criteria that should be used to evaluate proposed spouse abuse legislation or design new legislation in a comprehensive and coordinated manner.

The review of the literature, interviews with shelter directors and other experts, and other evidence presented in this report show a core of needs and problems that are fairly prevalent among battered spouses and, therefore, should be addressed in legislation. For example, spouse abuse has been shown to be a universal phenomenon, cutting across income, occupational, racial, ethnic, and religious groupings. Setting income eligibility requirements discriminates against women who, though they may come from higher income homes, may have fled those homes for safety with little more than a suitcase of clothing with them. This situation strongly suggests that services should be provided to battered spouses without regard to their income or the incomes of the batterers.

This type of reasoning has led to the legislative criteria which are listed below and then described in detail. These criteria can be used to evaluate proposed legislation or to design new legislation for the prevention and treatment of spouse abuse. Such legislation should:

- Contain specific goals that are aimed at the prevention, reduction, and treatment of spouse abuse.
- Foster the creation of comprehensive community networks of services needed by battered spouses.
- Provide for programs of community education to heighten awareness of and involvement in the goals of the legislation.
- Create a national data base on the incidence, types of treatment, services available, and unmet needs that must be provided for abused spouses.
- Authorize national agencies at the State and Federal levels to implement spouse abuse programs.
- Make eligible for services under the program all battered women, regardless of income.
- Provide for research and demonstration funds.
- Provide training funds.
- Provide for technical assistance to agencies offering services to battered spouses.
- Provide funding to evaluate the effectiveness of programs under the legislation.

Several of these criteria, particularly those concerned with the national data base, evaluation, training, and technical assistance, are included because they create tools for achieving and maintaining program excellence. Since this is a new area with many special problems and needs, the personnel working in the area will need training and technical assistance that is focused in the area of spouse abuse prevention and treatment. The creation of a national data base and the development of a body of evaluative information will assist Federal and State policymakers in determining where technical assistance and training is most vitally needed in the program agencies and where they should focus their efforts to increase the effectiveness of the programs. A discussion of the above listed criteria follows:

- Contain specific goals that are aimed at the prevention, reduction, and treatment of spouse abuse.

To provide focus and direction for programs, legislation must have clearly enunicated goals. Among those to be considered are:

(1) To prevent spouse abuse.

(2) To mobilize services where abuse has occurred to assure the well-being of the abused and that the abuse is not repeated.

(3) To support State and local governments in the development of interagency networks of services for abused spouses and their families.

(4) To assist in making existing service agencies more responsive to the needs of abused spouses and their families.

(5) To assist in the identification of spouse abuse cases.

(6) To make the public aware of the problem of spouse abuse in the United States.

(7) To collect data on the nature, causes, and incidence of spouse abuse in the United States.

(8) To evaluate the effectiveness of federally supported services to abused spouses and their families.

• Foster the creation of comprehensive community networks of services needed by battered spouses.

This study has found that victims of domestic violence enter the community service system at a variety of different, often independent, points: hospital emergency rooms, police calls, social service agencies, and community mental health agencies. The study has also found that these victims need a variety of services in different combinations, depending upon their particular circumstances. Both of these findings strongly support the importance of developing a service network in the community that is staffed by trained and knowledgeable people who can provide the range of services needed on a timely basis. This core objective cannot be achieved simply by creating another categorical Federal program. What is required is a variety of mechanisms, including incentives, that will facilitate the development of comprehensive service networks. Ultimately, such mechanisms and incentives will have to be concerned with program funding, uniform eligibility requirements, and formal comprehensive planning requirements.

The availability of planning funds can be very helpful in the development of service networks. One of the major reasons for the success of the Older Americans Act, as amended, for example,[5] has been the availability of planning money under that act to help States and localities develop comprehensive plans for services and other assistance to the elderly. Without such funds it is very difficult for new agencies to devote the time and utilize the expertise necessary to locate relevant community resources and negotiate working relations with them. Therefore, one criterion for legislation should be 100 percent Federal funding on a one-time basis for development of State and local comprehensive plans for the prevention of spouse abuse and the provision of assistance to the victims of such violence. Resulting local and State plans should be required to be incorporated in the State Title XX plan submission. This would greatly facilitate the development of a comprehensive plan that utilizes Title XX services.[6] The spouse abuse service plan, however, should be a distinguishable part of the Title XX plan submission, which should be submitted to the lead Federal agency in the battered spouse area for review and approval.

Another feature of the Older Americans Act that contributed to its success was the provision of funds at the State and local level to support staff members whose primary task was to create a community-based service network based on the comprehensive service plan. The model legislation should include 100 percent Federal funding for a maximum of 3 years to support this role and set of responsibilities.

Federal matching ratios could also be used to achieve the goal of a comprehensive service network. Consideration should be given to a sliding scale of Federal matching ranging from 65 to 100 percent, depending on the amount of funds from categorical programs that are reprogrammed into the spouse abuse program and plan. In other words, if a State or locality creates a plan that reprograms significant funds from community health services, LEAA and police, Title XX social services, community mental health, and housing, then that State or locality would receive a higher level of matching funds for its program. This provision might also be time limited, so that after a certain number of years—for example, 3 years—when the service networks have been institutionalized, the matching would be stabilized at 75 percent, which would be in line with most other Federal programs. This approach would give the States and localities a motivation to create comprehensive service networks. Once organized and running, the spouse abuse networks would be more likely to be able to compete successfully with other, existing programs.

• Provide for programs of community education to heighten awareness of and involvement in the goals of the legislation.

Experience with implementation of the Child Abuse and Neglect Act has shown the value of heightened community awareness and involvement. Such awareness and involvement is needed in the domestic violence area. The media can be used to sensitize the community to the problem, creating a willingness to support spouse abuse programs as well as to report instances of spouse abuse. Awareness campaigns can also do much to help abused women overcome self-imposed barriers to seeking help. Through grassroots involvement in sharing information on spouse abuse and through public media campaigns the problem can become known.

[5] 42 U.S.C. §§3001-3056f(1976).

[6] 42 U.S.C.A. §§1397-1397f(Supp. 1979).

• Create a national data base on the incidence, types of treatment, services available, and unmet needs that must be provided for abused spouses.

For the many reasons described earlier in this report, spouse abuse is underreported in national and local statistics. In addition, the Federal agencies responsible for national data collection have not gathered data on spouse abuse in their regular reporting formats; neither have data been obtained locally or statewide. Unless a problem is identified as such, there is no reason to collect data about it; conversely, until the data are collected no substantiation of the dimensions, services provided, unmet needs, incidence rates, etc. can be made. The lack of a national data base also makes research and planning difficult. Legislation should provide for the collection of national data. Additionally, common data elements regarding spouse abuse need to be defined and incorporated into case management systems across service agencies. Such systems could then generate needed program management and performance data on the problem of spouse abuse. Collaboration will be needed from agencies serving victims of violence regarding the development of common definitions of terms.

• Authorize national agencies at the State and Federal levels to implement spouse abuse programs.

A Federal agency must be designated to oversee all Federal spouse abuse program activity. This agency should set Federal policy by working with other relevant Federal agencies. Its placement within the Federal establishment should be at the discretion of the President. The agency should provide grants to designated State agencies and monitor their implementation through the review and approval of State annual plans and program performance data.

This agency should develop a national data base and use the findings to assist in setting national priorities and directions. It should be accountable to the President and Congress through the submission of an annual report of its activities.

A similarly responsible agency at the State level to provide focus, direction, and oversight of spouse abuse programs is critical to any Federal spouse abuse legislation. The State agency should be housed in the State planning office (similar to the criminal justice State planning agency) or created as a bureau within the conglomerate human services department. It should include within its responsibilities the development of an annual State plan for submission and approval to the designated Federal spouse abuse office. The plan should include objectives and activities, as well as the incidence data upon which it is based.

The legislation should require the States to submit plans for review and report quarterly on both case data and financial expenditures.

• Makes eligible for services under the program all battered women, regardless of income.

As discussed above, spouse abuse is not restricted to a single income level, race, religion, or geographic area. Yet, eligibility for most Federal services is restricted in one manner or another (e.g., low income, urban area). To assure the receipt of services by *all* abused spouses, universal eligiblity is required. State plans and local contractor proposals should be required to certify that eligibility for receipt of services is based upon this understanding. Efforts to expand eligibility in existing agencies should be a requirement of both States and local contractors.

• Provide for research and demonstration funds.

Knowledge about the causes and dynamics of the violent family is in its infancy. Only when the knowledge base has increased can improved treatment methodologies be tested. Field testing of new methods is also badly needed.

• Provide training funds.

Many human service practitioners are not experienced in treating the unique needs of the victims of spouse abuse, and others are fearful of becoming involved in what they see as "private" matters. Training is requisite if practitioners are to provide quality services to spouse abuse victims and their families. These practitioners will need information on the available services and proper referrals, the causes and dynamics of the abuse syndrome, and technical skills. Shelter staff could benefit from planning and management training, including the conduct of needs assessments, developing networks, community involvement campaigns, agency management control systems, budgeting and accounting, and so on.

• Provide for technical assistance to agencies offering services to battered spouses.

Technical assistance should be made available by the Federal spouse abuse program-sponsoring agency to States and local contractors. Assistance should focus on the implementation of the spouse abuse system as created by the law. This includes working with designated State agencies on annual plan

development, statewide needs assessments, data collection systems, purchase-of-service contracts, contract monitoring, and financial accounting and reporting. Local contractors should be able to obtain technical assistance for the full range of their efforts, including initiating the work, developing staffing patterns, agency management, interagency coordination mechanisms, conducting needs assessments, and data collection and correlation.

- Provide funding to evaluate the effectiveness of programs under the legislation.

Any federally funded program must assure taxpapers that it is effectively using the funds allocated. This is particularly true of an effort in which new techniques will be developed and then tested. Further, each local and State program also should be held accountable for meeting its stated objectives or show the reasons why they were not achieved. A spouse abuse law should require that an independent evaluation of the effectiveness of the Federal program in meeting its legislated goals be conducted and submitted to Congress and the President annually. The results should be used in determining the appropriate next step after the authorization is completed. In turn, the Federal sponsoring agency should require that the results of an independent evaluation be submitted by all State-designated agencies for review before approval of the State's annual plan. The States, similarly, should assure that local contractors' performance in achieving their contractual obligations is evaluated before re-funding. Only in this manner can new knowledge be reflected in new practice and the accountability for public funds be properly maintained.

Chapter 12

Common Issues

This study has reviewed 19 major Federal programs and several others that illustrate the range of Federal resources which can respond to the major needs of victims of spouse abuse and organizations that serve them. It also briefly described several Federal initiatives on domestic violence during 1979–1980.

The pattern that emerges in the preceeding chapters is that the use of Federal programs in addressing domestic violence is relatively recent and, in large part, sporadic. It should be noted, however, that several efforts were underway directed to a coordinated Federal response to battered women.

Because spouse abuse had not yet emerged as a major social problem during the initial development of the programs examined, abused women were not identified as a potential target for their services. Nevertheless, as demonstrated in the previous chapters, service structures established by these programs have been and can be used to meet the needs of battered women and the organizations that serve them. For the period examined, 1979–1980, the mechanisms for providing services to victims of spouse abuse and their families through Federal programs were slowly emerging with limited funds and newly developed support. Federal programs provided assistance to efforts at local and State level where, often, decisions on priority use of Federal funds were made. Additionally, there were several instances of joint funding of domestic violence projects by Federal agencies.

While the Federal response to battered women during the conduct of this study had been slow and less than adequate, projected Federal budget cuts and block grant proposals for many human services programs suggest that continued Federal activities related to domestic violence and other human services are uncertain. If a Federal response to battered women is to be maintained, Federal agencies must reassess their authority and develop more creative and effective uses of diminishing resources in cooperation with State and local agencies. As a first step, Federal agencies can review past and present Federal activities, including those described in this report, as a basis for future activities.

In the course of reviewing the programs in this report, several issues were identified that must be resolved to improve Federal responsiveness to the problem of spouse abuse. These issues are common and recurring to some, if not all, the programs reviewed.

Following are statements of these issues and suggestions for their resolution at broad and program-specific levels.

1. *The general public is unaware of the extent and seriousness of the problem of domestic violence.*

Until very recently, spouse abuse had been a problem hidden in the confines of the family. Violence between adult family members has traditionally been treated as a private matter by public institutions that have authority to intervene. This lack of public awareness of the problem has helped to convey an attitude of acceptance of violence against women by their mates. The message that spouse abuse is a crime and will not be tolerated has not been conveyed. Abused women, fearing they

would be blamed for the abuse, have been hesitant to come forward, too often told to go back home where they belong, and condemned for bringing private family matters to public attention. Until the emergence of the shelter movement, women had few places to seek refuge from the violence. Once the doors of the shelters were opened, however, the dimensions of the problem began to be revealed.

Generally, however, communities remain unaware of the scope of the problem. Media attention that could help to expose the problem is lacking. Community service agencies that could help to increase awareness of the problem have not dealt with it publicly.

Community awareness of the problem is important for several reasons. It is a first step toward encouraging public support for measures such as legislative reform and funding for spouse abuse projects. Strong community attitudes against violence in families may stimulate prevention efforts as well as promote greater use of sanctions in spouse abuse cases. Increased community interest in the problem can encourage organizations such as hospitals, police, mental health centers, and social service agencies to devote more attention and more resources to its resolution. Greater community concern about spouse battering can also be a catalyst for community-wide planning efforts to identify needs of victims and their families and to develop services that are lacking.

None of the Federal programs reviewed in this report was found to have made special efforts to disseminate information on spouse abuse to the general public. The development of pamphlets and brochures, radio and TV spot announcements, or films to increase public awareness is needed and should receive greater Federal support.

Recommendation: Federal agencies supporting services to battered women should develop and implement programs, in conjunction with appropriate State and local agencies, to heighten community awareness of spouse abuse and available services.

- The National Institute of Mental Health, Department of Health and Human Services, should issue guidance to Community Mental Health Centers suggesting, as part of their requirement to provide consultation and education to community groups, that local agencies serving battered women be included through the development of a formal affiliation agreement, and at no fee, if the agency can show it does not have funds to pay for consultation service.
- The National Institute of Alcohol Abuse and Alcoholism (NIAAA), Department of Health and Human Services, should issue an educational pamphlet on the relationship of alcohol and spouse abuse for distribution to all NIAAA prevention coordinators.
- The National Institute on Drug Abuse, Department of Health and Human Services, should issue an educational pamphlet on the relationship of drug abuse and spouse abuse for distribution to its local contractors and grantees.
- The Bureau of Indian Affairs should help to educate tribal governments concerning the needs of abused Indian women and their families and encourage the development of needed services.
- The Department of Justice (DOJ) should identify effective spouse abuse programs in criminal justice agencies, whether or not they receive financial support from the Department, and disseminate information about them to other agencies. The States should be strongly encouraged to adapt these effective practices to local problems and conditions. DOJ should monitor State implementation of these practices.

2. *There is a consistent lack of data collection on spouse abuse.*

Statistical evidence supporting the staggering dimensions of spouse abuse has been growing during the past few years. National surveys and local studies indicate that wife abuse is a widespread problem cutting across racial and economic lines. Even though the number of shelters available to victims is growing, they do not yet meet the demand for service, providing additional evidence of the national significance of the problem.

Although the severity and prevalence of the problem of spouse abuse can be substantiated, its exact proportions are unknown. Because both caseworkers and agency administrators have not been sensitized to the seriousness and extent of spouse abuse, data are not being collected systematically that could be useful for planning and improving services. Agency reporting systems generally do not include categories related to spouse abuse. Police reporting systems, for example, may collect information on the general category of assault, but often do not separate assault that occurs between strangers from assault that occurs between nonstrangers, particularly husbands and wives. A circular problem

results. Without sufficient data to substantiate the problem, there is likely to be limited interest and concern. Without interest and concern, adequate provision for data collection is unlikely.

Improving data collection systems involves many complex issues. Agencies must determine what type of information is needed, which staff will collect it, how it will be obtained, and how it will be used. To collect the needed data, changes will be required in intake and client registration forms. For computerized data collection systems, changes would be required in computer programs that may require substantial costs. Staff training is also an issue related to data collection. Staff must be trained in the data collection methods as well as in how to identify the problem so that it can be documented. Issues of privacy and confidentiality must also be addressed, including the sharing of information among various service agencies that may be involved in spouse abuse cases.

Data are needed to plan for the type and amount of services that can provide the greatest assistance to victims and other family members and to support the need for funding of domestic violence programs.

None of the Federal programs reviewed in this study was found to have developed data collection systems that provide current and continuing information on spouse abuse. Some agencies have initiated efforts to determine how various programs are being used to assist victims or organizations serving victims. Although this type of information is useful, it falls short of the Federal Government's responsibility to examine the extent and effect of what appears through existing evidence to be a major social problem.

Recommendation: All Federal agencies supporting services needed by battered women should develop and implement data collection procedures, using uniform definitions, that result in regular national reporting of services requested by and provided to battered women and their families.

- The Bureau of Justice Statistics, Department of Justice, should work with all Federal justice agencies to develop standard definitions of spouse abuse and incorporate them as specific subcategories in all data collection efforts.
- The Bureau of Community Health and the National Institute of Mental Health, Department of Health and Human Services, should develop reporting materials requiring Community Health Centers and Community Mental Health Centers, respectively, to report on incidence and current treatment being provided to abused spouses and abusers in their areas. The data obtained should be examined to determine if spouse abuse warrants establishing abusers and abused as priority target groups. Similarly, the Department of Defense's Family Advocacy Committee and the Veterans Administration should develop such materials for military and VA hospitals, respectively.
- The Department of Health and Human Services should include in its standard social services reporting forms, including but not limited to Title XX, a count of spouse abuse victims served by these programs.

3. *Spouse abuse has not been made a priority concern of agencies.*

Because of the lack of awareness of the problem of spouse abuse and the inadequate data collection to substantiate its extent, it has not received priority attention by most Federal agencies. Unless spouse abuse is made a high priority, significant resources will not be devoted to staff training, improved data collection, development of more effective practice techniques, or more extensive services.

Two Federal agencies, HHS and LEAA, have demonstrated their awareness and concern by establishing offices on domestic violence, but the funding for both offices has been relatively insignificant. Further, these offices have been or are being phased out. The Legal Services Corporation has created a National Center on Women and Family Law, but its funding is not commensurate with the scope of the problem. Most agencies, however, have not devoted resources specifically to the problem of spouse abuse.

Some of the programs reviewed in this study are authorized to give priority service to specific target groups with the most pressing needs. Single persons, for example, are eligible for section 8 housing. However, single persons who are elderly or handicapped are given priority. The hospitalization and outpatient services program of the Veterans Administration is another example in which priority categories for services have been established. None of the programs reviewed specifically identifies victims of spouse abuse as a priority group for service, despite the fact that lack of service may place them in life-threatening situations.

Recommendation: Federal agencies that support services needed by battered women should establish spouse abuse as a priority problem to be addressed.

• The Office of Human Development Services (OHDS), Department of Health and Human Services, should encourage State social services agencies to include battered wives and their children in their needs assessment for Title XX services.

• ACTION should assign national priority status to the placement of VISTA volunteers and foster grandparents in local nonprofit agencies serving battered women.

• The National Institute of Mental Health should direct Community Mental Health Centers to designate spouse abuse victims, abusers, and their children as a special group for receipt of priority attention.

• The Department of Housing and Urban Development should clarify that the eligibility criteria for section 8 housing does not exclude victims of spouse abuse.

4. *Eligibility criteria limit the access of victims to services.*

Spouse abuse affects women regardless of their economic status. Programs for abused women report that they serve clients from low-, middle-, and high-income families. When a woman leaves home to escape further violence, she may no longer have access to the family income. She may have little or no cash on hand and no way to obtain any of the family resources. Although many public services programs were clearly designed to help low-income persons, they do not always take into consideration the unique circumstances of an abused woman whose economic status can change in a matter of minutes.

The needs assessment telephone consultations and the literature review found that abused women have been denied eligibility for some services because their husbands' incomes were taken into account in determining income status, despite the fact that those incomes were inaccessible to them. Because this study did not allow for field visits at the local level, it was not possible to determine the extent of this problem. Federal legislation and regulations reviewed in this study do not require or in some cases do not allow inaccessible income to be included in the eligibility determination. However, this problem is being reported by staffs of shelters and programs that work with abused women. Therefore, Federal agencies should clarify eligibility regulations to their State and local counterparts and monitor their application in spouse abuse cases.

Emergency services are offered through both State and Federal social service programs. This study reviewed the AFDC emergency assistance program available in 21 States, and found that it is not being implemented to the full extent possible within the Federal regulations. Additionally, the needs assessment found that in some localities abused women experienced long waiting periods while applications were being processed before emergency cash assistance was made available to them. Because of the life-threatening circumstances of the victim, emergency services are of critical importance. If emergency services such as housing, food, or cash assistance are unavailable, abused women may be forced to return home to face further violence or they may find it impossible ever to leave. Emergency services for victims should be available without regard to income. The Federal Government should take the lead in granting universal eligibility for emergency services to abused women and should encourage States to do the same for State-sponsored emergency service programs.

Recommendation: Regulations concerning eligibility for all federally-supported emergency services should be amended to specify that battered women are eligible for these services without regard to inaccessible income.

Recommendation: Federal regulations concerning eligibility for needed services should be amended to include battered women as an eligible service population and to indicate that financial resources that are not accessible shall not be considered in determining eligibility.

• The Department of Housing and Urban Development (HUD) should clarify regulations concerning income eligibility criteria for federally supported, short-term (transitional) and long-term housing to ensure that abused women are not excluded because of their husbands' income. HUD should monitor State and local implementation of these regulations.

• The Family Assistance Program, Department of Health and Human Services, should issue a clarification of Federal regulations on child support reporting requirements in cases where there is danger of physical or emotional harm to the mother or child. FAP should monitor State and local implementation of these regulations.

• The Family Assistance Program should clarify Federal regulations to emphasize that only accessible income may be included in the determination of

income eligibility for AFDC. FAP should mointor State and local implementation of these regulations.

- The Public Services, Administration, Department of Health and Human Services, should designate priority status for the receipt of day care funded through Title XX to program participants who are seeking to leave abusive family settings and for whom the receipt of day care for their children is a prerequisite to employment and financial independence. Consideration for the offering of such day care through contracts should be given local organizations with experience in serving battered women.
- The General Services Administration (GSA) should clarify its guidelines for receipt of surplus personal property to include local nonprofit agencies serving battered women as eligible within either the "public health" or "education" organizational definition of eligibility. GSA should monitor State and local implementation of these guidelines.
- The U.S. Department of Agriculture (USDA) should clarify its guidelines for receipt of donated surplus food to include nonprofit agencies serving battered women as eligible within the "charitable institution" definition of eligibility. USDA should monitor State and local implementation of these guidelines.

5. *There is a lack of coordination of services to respond effectively to the needs of victims and their families.*

The problems of spouse abuse are multicausal in nature and therefore require a coordinated, multiagency response. The existing resources within a community are often fragmented and unable to respond to meet the various protective and supportive needs of the abusive family.

Although one agency in a community may be identified as having the primary responsibility for service delivery to an abused spouse, no single individual or agency has the necessary skills or resources to provide all services needed by families. Comprehensive service delivery must involve the combined skills and cooperation of various disciplines to be effective.

A coordination plan for carrying out activities in such a way that efforts to attain common goals are not duplicated is essential to comprehensive service delivery. Coordination requires concerted efforts on the part of all those involved to create and maintain the kinds of organizational linkages, communication, and mutual agreements to make it possible for agencies, organizations, and individuals to work together.

Participants in coordination efforts need a forum where they can meet. This forum can be in the form of a consortium of agencies or a coordinating committee. The committee could include service providers only or providers and citizen representatives. Leadership is also required to bring together the various agencies and individuals involved in service delivery. At the community level this leadership could emerge from a local shelter, a self-help group, a social service agency, an advocacy group, the courts, the police, or a hospital.

Once participants begin to exchange information and define their tasks in the total service delivery network, linkages should emerge that can result in the development of referral arrangements and procedures for sharing of information, as well as joint funding arrangements for the development of needed services. Efforts to increase public awareness to the problem of spouse abuse can also be more effectively developed by a concerted effort of the participating groups. The coordination forum itself can begin to act as the entity which advocates change and innovation for serving spouse abuse victims.

Although the Federal Government has sought to coordinate its efforts by the establishment of the Interdepartmental Committee on Domestic Violence, the result is little more than cosmetic since no real authority or money has been vested in it. Although this study did not undertake a systematic review of parallel efforts at the State and local level, the review of the literature and telephone consultations appear to indicate that coordination activities at these levels are minimal. One of the factors that seems to inhibit greater coordination is that no agencies at the local and State levels are designated to take the lead in the domestic violence area.

Recommendation: Federal agencies supporting services needed by battered women should encourage the coordination of services at the State and local level by the organizations they support.

- The National Institute of Mental Health Should develop guidelines for distribution to the Community Mental Health Centers, and other interested community agencies, regarding the development of crisis intervention services for spouse abuse victims and their families, including identification, diagnosis, emergency treatment, and appropriate referral procedures.

- The National Institute on Alcohol Abuse and Alcoholism should issue policy guidance to its grantees to assure the appropriate sharing of spouse abuse records, with client permission, with other local agencies involved with the same cases, to facilitate cooperative treatment.
- The National Institute on Drug Abuse and the National Institute on Alcohol Abuse and Alcoholism should issue a directive to all local grantees and contractors encouraging establishment of interagency working agreements with local agencies serving battered women.
- The Bureau of Community Health, Department of Health and Human Services, through an administrative memorandum to regional offices, should encourage Community Health Centers to develop working agreements with local shelters for specialized spouse abuse services.
- The Public Services Administration (PSA), Department of Health and Human Services, should encourage State public welfare agencies to develop working relationships with local agencies serving battered women and encourage State Title XX designated agencies to support statewide coalitions or task forces designed to plan for the needs of abused women. PSA should monitor State Title XX and public welfare agencies efforts in this area.

6. *There are inadequate research, evaluation, and demonstration efforts to improve service delivery.*

Although some efforts have been made to increase the knowledge base regarding spouse abuse, information on its causes and on potential solutions is still inadequate. The relationship between spouse abuse and child abuse and the effects on children growing up in violent homes has yet to be fully explored. Little is known about effective approaches to working with the abusers or about effective prevention methods. Those working with violent families are doing so without the benefit of a sound theoretical and practical framework. Often, spouse abuse projects operating on limited budgets do not have funds to evaluate their programs, which would add to the knowledge base regarding effective practice methods. Additionally, longitudinal studies are needed to examine the longrange effectiveness of methods used in intervention programs.

Although many of the programs reviewed in this study are authorized to conduct research and demonstration projects, only a few have targeted research and demonstration funds for the area of spouse abuse. The Center for Studies of Crime and Delinquency (NIMH) has sponsored research on the incidence and causes of spouse abuse. Funding for the Center's research in spouse abuse, however, was reduced significantly in 1980. The Office of Family Violence (LEAA) and the Office of Domestic Violence (HHS) have sponsored demonstration projects that test various methods for intervention and coordination of services.

Many other Federal agencies, however, have potential to further knowledge about working with violent families and about the causes and effects of spouse abuse. Very little is known, for example, about the extent of the problem within military families and on the possible relationship between military training and violence in military families. However, no major research efforts by the Department of Defense on family violence were identified in this study.

Research regarding the male abuser and effective methods of treating abusers is extremely limited. The Veterans Administration, because of the large population of males served through its health care system, can play a major role in conducting research on the abuser and methods of identification and treatment. The Veteran's Hospital in Tacoma, Washington, has begun to develop methods for identification and treatment of abusers; however, no major research efforts or plans for research on family violence by the Veterans Administration were identified in this study.

The relationship between alcohol abuse, drug abuse, and family violence is another area in which knowledge is limited. The National Institute on Alcohol Abuse and Alcoholism and the National Institute on Drug Abuse have the potential to explore this area through their authorized research programs.

Recommendation: Federal agencies supporting services needed by battered women, their children, or their abusing husbands should support research, evaluation, and demonstration projects to further knowledge about the problem.

- The National Institute of Justice should focus its research efforts on the problems of the criminal justice system that affect victims of domestic violence and the problems experienced by victims in their dealings with justice agencies.
- The National Institute on Alcohol Abuse and Alcoholism should examine its focus on serving individuals and determine how a family approach could be used in spouse abuse cases in which

alcoholism is a concern and where the spouse abuser is willing to participate.

- The National Institute on Drug Abuse should examine its focus on serving individuals and determine how a family approach could be used in spouse abuse cases in which drug abuse is a factor and where the spouse abuser is willing to participate.
- Consistent with the objectives of its recent directive on a family advocary program, the Department of Defense should initiate exploratory research on the causes, scope, and effects of spouse abuse in military families.
- The Veterans Administration should conduct a feasibility study on methods for identification and treatment of abusers, based on preliminary research such as that done in the Veterans Hospital in Tacoma, Washington.

7. *There are not enough adequately trained personnel to work with victims and their families.*

Training is needed by all the service professions. Findings from the needs assessment indicate that medical staff who treat the physical injuries of abused women often fail to recognize the cause of these injuries. Attention may also be focused on secondary problems related to battering, such as depression and psychosomatic illness, rather than on the source of these problems. The issue of identification of spouse abuse is also relevant to other professions such as mental health, social work, and the law. Battered women may be fearful or ashamed to discuss their problem. Human service practitioners need to be able to recognize clinical indicators of spouse abuse as well as to conduct sensitive interviewing that will encourage exposure of the problem.

Training needs to occur on several levels, including identification of the problem, understanding family dynamics, and intervention approaches. Because spouse abuse is only beginning to be recognized as a major social problem, traditional professional education programs have generally not included spouse abuse as an area of study. In the review of Federal programs in this report, very few training initiatives related to spouse abuse were identified. Most of the programs, however, are authorized to provide funds for staff training.

The issue of training is closely related to research and evaluation, which can advance knowledge of how to work with violent families. With such advances, more effective training programs can be developed. Training programs, however, should not be delayed simply on the score of insufficient knowledge. Rather, training programs should be developed based on existing knowledge and modified as the knowledge base widens.

Recommendation: All Federal agencies supporting services needed by battered women or their families should develop training programs for Federal, State, and local staff.

- The Office of Human Development Services (OHDS), Department of Health and Human Services, should encourage states to develop training programs for social services staff to enable them to identify and work effectively with abused women and their children. OHDS should monitor State and local implementations of these programs.
- The Bureau of Indian Affairs should provide training to staff of social welfare programs to increase their awareness of the problem of spouse abuse and to assist them in working more effectively with victims and their families.
- The National Center on Child Abuse and Neglect, Department of Health and Human Services, should develop training materials for child protective service workers to help them identify spouse abuse that may also be occuring among families in their caseloads.
- The Department of Health and Human Services should develop training materials for staff of all children's programs, such as Title XX day care and Head Start, to raise their awareness of spouse abuse and to help sensitize them to the needs of children in violent homes.
- The National Institute on Mental Health should develop training materials for distribution to Community Mental Health Centers, and for use by other local mental health services agency staff, on the unique mental health needs of abused spouses and abusers and the types of treatment most effective in meeting these needs.
- The Bureau of Community Health, Department of Health and Human Services, should determine the proper vehicle to assure that spouse abuse training materials are developed for distribution to general hospital emergency room personnel.
- The Department of Defense's Family Advocacy Committee should develop spouse abuse identification, treatment, and referral training materials for distribution to military hospital emergency room personnel.
- The Veterans Administration should develop spouse abuse identification, treatment, and referral

training materials for distribution to VA Hospital emergency room personnel.

- The Public Services Administration, Department of Health and Human Services, and the Employment and Training Administration, Department of Labor, should develop guidance materials for distribution to State public welfare agencies administering the Work Incentive program (WIN) suggesting how the unique prevocational needs of abused women can best be met.
- ACTION should develop planning and management training materials for use by volunteers assigned to local organizations serving battered women.

8. *There is an inadequate supply of technical assistance to assure effective management of domestic violence programs.*

Programs serving victims and their families are often grassroots programs with very limited budgets and small staffs. Administrators may not have management skills needed in areas such as resource development, planning, forming networks, financial management, and staff development. Administrators of spouse abuse programs are often unfamiliar with the Federal bureaucracy and lack information on Federal programs that might support their programs. Even if they are aware of the sources of potential funding, they may lack technical skills in proposal development and grant writing. Technical assistance is needed for these administrators.

This study found very few Federal efforts specifically designed to disseminate information about Federal funding to spouse abuse projects or to provide technical assistance in management or in obtaining Federal dollars.

Recommendation: Federal agencies should provide technical assistance to organizations serving battered women and their families, to ensure that quality services are provided.

- ACTION should assign national priority status to the placement of RSVP volunteers, particularly those experienced in marketing, planning, and management, in local nonprofit agencies serving battered women.
- The Department of Housing and Urban Development should make its technical assistance available to help organizations serving battered women learn about HUD programs relevant to the housing needs of battered women and apply for funds.
- The National Center on Child Abuse and Neglect should provide technical assistance to local community programs serving children of domestic violence victims.

9. *Services are not widely available to those who need them.*

Services to victims have been established largely through the efforts of dedicated volunteers and women's groups. Shelters were developed in areas where the need was recognized and women were able to pool their energies and resources to meet the need.

Through the shelter movement the problem of spouse abuse has been brought to public attention. Although data on the extent of the problem are inadequate, the evidence from national surveys, local studies, and the numbers of women seeking the service of shelters indicate that the problem is widespread and that the need for service is extensive.

Statewide planning for services is needed to ensure that the needs of all relevant client groups (including victims of all age groups, from ethnic and minority groups, and from both rural and urban areas; children of victims; and abusers) are assessed and that services are planned to meet those needs. Additionally, statewide planning efforts can encourage greater coordination of services, resulting in a better use of limited program dollars.

Recommendation: The Federal Government should encourage statewide planning efforts by making planning grants available to the States. Requirements for the receipt of a planning grant should include the participation of direct service providers and advocacy groups in the planning process.

Appendix A

Methodology

The purpose of this study was to:

- Identify and summarize initiatives by Federal agencies in 1979 and 1980 for shelter and local community organizations that serve the needs of adult female victims of domestic violence;
- Assess the adequacy and relevance of such initiatives in light of the needs of such organizations and of the total Federal program resources available; and
- Propose recommendations, including necessary administrative and legislative actions, to Congress and the President, directed at providing for the needs of female victims of domestic violence in a comprehensive and concerted national effort.

To accomplish these objectives, the Commission designed four tasks:

- An assessment and examination of the needs of spouse abuse victims and shelters and community organizations providing services to victims;
- A program-by-program analysis of selected existing Federal program legislation in terms of adequacy and potential, as well as an identification of barriers to the provision of services to spouse abuse victims;
- An analysis of proposed Federal legislation to meet the needs of victims; and
- Recommendations regarding the means by which existing and proposed legislation could best provide comprehensive nationwide assistance to State and local community organizations providing services to battered spouses.

This appendix describes the procedures followed in completing these tasks.

Needs Assessment

The purpose of the needs assessment was twofold: to identify the priority needs of spouse abuse victims and of the shelters and community organizations serving them; and to provide a basis for an analysis of the extent to which Federal programs and pending legislation meet these needs. These identified needs were assessed through an analysis of the current literature on domestic violence and through telephone consultations with direct service providers, national organizations, and task forces.

Criteria used to select documents for the literature review included materials that presented an overview of the problem and examined the nature and extent of spouse abuse and materials that focused on the service needs of battered women, barriers to providing those services, and the development of model programs.

Literature Review

In selecting documents to be included in the literature review, project staff examined current bibliographies on spouse abuse, as well as materials available from policy studies. During the telephone consultations, interviewees identified additional documents that had particular relevance to needed services and barriers to service delivery which were also obtained and examined. The sources for the literature reviewed and used during the needs assessment are listed below.

List of Sources For Literature Review

Books

Fleming, Jennifer Baker. *Stopping Wife Abuse.* Garden City, N.Y.: Anchor Press/Doubleday, 1979.

Martin, Del. *Battered Wives.* San Francisco: Glide Publications, 1976.

Roy, Maria. *Battered Women, A Psychological Study of Domestic Violence.* New York: Van Nostrand Rheinhold, 1977.

Walker, Lenore. *The Battered Woman.* New York: Harper & Row, 1979. Journals, Periodicals, Newsletters

Durnning, Kathleen P.; Hunter, Edna; Marsden, Martha; and McCurbin, Hamilton. "Family Policy, in the Armed Forces." *A University Review,* vol. 29, 6, Sept.-Oct. 1978.

Eisenburg, Susan E., and Michlow, Patricia. "The Assaulted Wife: Catch 22 Revisited." *Women's Rights Law Report,* vol. 3, no. 22, April 1977, pp. 4025–28.

Fields, Marjorie. "Representing Battered Wives or What to Do Until the Police Arrive." *The Family Law Reporter,* vol. 3, no. 22, April 1977, pp. 4025–28.

Fromson, Terry. "The Case for Legal Remedies for Abused Women." *NYU Review, Law and Social Change,* Spring 1977, pp. 135–74.

Parnas, Raymond. "Prosecutional and Judicial Handling of Family Violence." *Criminal Law Bulletin,* vol. 9, no. 9, November 1973.

"Response," Newsletter. A Project of the Center for Women Policy-Studies, vol. 2, nos. 2–9, vol. 3, nos. 3–4.

Stark, Evan; Flitcraft, Anne; and Frazier, William. "Medicine and Patriarchal Violence: The Social Construction of a 'Private' Event." *International Journal of Health Services,* vol. 9, no. 3, 1979.

Victimology, An International Journal, vol. 2, nos. 3–4, Visage Press, 1977–78.

Government Documents and Testimony

Bergen County Advisory Commission on the Status of Women, "Crimes of Violence Against Women; Rape/Battered Women," Spring 1977.

Colorado Advisory Committee to the U.S. Commission on Civil Rights, "The Silent Victims: Denver's Battered Women," August 1977.

Colorado Association for Aid to Battered Women, "A Monograph on Services to Battered Women," Draft Report, prepared for DHEW, December 1978, sections I, II, III.

Connecticut Advisory Committee to the U.S. Commission on Civil Rights, *Battered Women in Hartford, Connecticut,* April 1979.

General Accounting Office, "Military Child Advocacy Programs: Victims of Neglect," May 23, 1979.

Law Enforcement Assistance Administration, "Conference on the Male Abuser," May 1–3, 1978, Belmont, Md.

State of New Jersey, Department of Human Services, Division of Youth and Family Services, "Physically Abused Women and Their Families: The Need for Community Services," Program Development Guide, Trenton, N.J., June 1, 1978.

U.S., Commission on Civil Rights, "Wife Beating: Causes, Treatment and Research Needs," Prepared for the Commission by Murray Straus, January 1978.

U.S., Commission on Civil Rights, *Battered Women: Issues of Public Policy,* A consultation sponsored by the U.S. Commission on Civil Rights, Washington, D.C., January 30–31, 1978.

U.S., Congress, House, Committee on Education and Labor, Subcommittee on Select Education, Hearings on Domestic Violence, July 10, 1979.

U.S., Congress, House, Committee on Science and Technology, Subcommittee on Domestic and International Scientific Planning Analysis and Cooperation, February 1978.

U.S., Department of Justice, "The Nature and Extent of Spouse Abuse," *The Victim Advocate,* A Special Criminal Justice Improvement Publication of the National District Attorney's Association, October 1978.

Woods, Laurie. "Litigation on behalf of Battered Women," *Women's Law Reporter,* vol. 5, no. 1, Fall 1978.

Papers, Presentations, Miscellaneous Reports

Dobash, Russell, and Rebecca E. "With Friends Like These Who Needs Enemies: Institutional Support for the Patriarchy and Violence Against Women." Paper presented at the Ninth World Congress of Sociology, Uppsala, Sweden, August 1978.

Fields, Marjorie. "Wife Beating, Government Intervention Polices and Practices."

U.S., Commission on Civil Rights, *Battered Women: Issues of Public Policy.* A consultation sponsored by the U.S. Commission on Civil Rights, Washington, D.C., Jan. 30–31, 1978.

Fotjik, Kathleen M. "The Buck Starts Here: How To Fund Social Service Projects." Ann Arbor, Mich., September 1975.

Ganley, Anne and Harris, Lane "Domestic Violence: Issues in Designing and Implementing Programs for Male Batterers." Paper presented at the American Psychological Association, Toronto, Canada, Aug. 29, 1978.

McCormick, Claudia. "Battered Women: The Last Resort," Unpublished paper by the superintendent of the Women's Correctional Center, Chicago, Ill.

Pagelow, Mildred. "Battered Women: A New Perspective." Paper prepared for presentation at the International Sociological Association Seminar on Sex Roles, Deviance, and Agents of Social Control, August 9–11, 1977, Dublin, Ireland.

Pagelow, Mildred. "Secondary Battering: Breaking the Cycle of Domestic Violence." Paper prepared for presentation at the annual meeting of the Sociologists for Women in Society Section of the American Sociological Association, Sept. 5–9, 1977.

Parnas, Raymond. "The Relevance of Criminal Law to Interspousal Violence." Second World Conference of the International Society on Family Law: Violence in the Family.

Saltzman, Katherine. "Family Violence Services." Position paper by the director of York Street Center, Denver, Colo.

Shulman, Mark. "A Survey of Spousal Violence Against Women in Kentucky." Conducted for the Kentucky Commission on Women by Louis Harris and Associates, Inc., July 1979.

Starr, Barbara. "Patterns in Family Violence." Unpublished paper presented at the 105th Annual Forum of the National Conference on Social Welfare Los Angeles, Calif., 1978.

Straus, Murray A.; Gelles, Richard J.; and Steinmetz, Suzanne V. "Violence in the Family. An Assessment of Knowledge and Research Needs." Presentation before the American Association for the Advancement of Science, Boston, Mass., Feb. 23, 1976.

Telephone Consultations

Method of Selection. The scope of this project did not permit the selection of a random sample from the universe of agencies providing services to battered spouses (by random sample each agency has an equal and known probability of entering the sample). Project staff reviewed testimony, as well as other forms of documentation, and consulted with knowledgeable people in the field to identify potential respondents and agencies meeting the selection criteria. Final selections were reviewed and approved by Civil Rights Commission staff.

Selection Criteria. Thirty-five respondents from agencies that represented a variety of approaches to the provision of services to battered spouses were selected. The selection criteria were designed to provide variability among the agencies. The criteria included:

- Geographic spread—The sample included agencies from diverse areas of the United States.
- Ethnicity—The sample agencies included those that were providing services to such minorities as blacks, Asians, Native Americans, Hispanics, as well as white American women.
- Knowledge of Federal programs—The sample included agencies that have attempted to obtain Federal funding for their programs.
- Type of agency—The sample included agencies ranging from shelters to community organizations that provided specialized services to battered spouses. The sample also included national advocacy organizations and research groups whose perspective would be helpful in assessing needs and barriers.

List of Respondents

Following is a list of respondents contacted for the needs assessment consultations. As well as meeting the selection criteria cited above, the following list of shelters reflects an effort to include a range of perspectives on the problems of spouse abuse and the services required to meet the needs.

Shelters

La Casa de Las Madres
San Francisco, Calif.
Contact: Jeannie Coltrin

Women's Advocates
St. Paul, Minn.
Contact: Monica Erler

Abused Women's Aid in Crisis, Inc.
Anchorage, Alaska
Contact: Kilt Evans

Chicana Service Action Center
Los Angeles, Calif.
Contact: Frances Flores

Ann Arbor Domestic Violence Project
Ann Arbor, Mich.
Contact: Kathy Fotjik

Aid to Women Victims of Violence
Cortland, N.Y.
Contact: Linda Hanrahan

Casa Myrna Vasquez
Boston, Mass.
Contact: Curdina Hill

Victim's Advocates Program of Dade County
Miami, Fla.
Contact: Catherine Lynch

House of Ruth Annex
Washington, D.C.
Contact: Vernonica Maz

Salvation Army Emergency Lodge
Chicago, Ill.
Contact: Gay Northrop

National Congress of Neighborhood
Women/Shelter Program
Brooklyn, N.Y.
Contact: Rosemary Reid

Family Violence Intervention Program
Integrated Crisis Services for Black Hawk County
Cedar Falls, Iowa
Contact: Sue Sweet

Harriet Tubman's Women's Shelter
Minneapolis, Minn.
Contact: Sharon Vaughan

Transition House
Cambridge, Mass.
Contact: Rosemary Ward

Hubbard House/Women's Rape Crisis Center
Jacksonville, Fla.
Contact: Shirley Webb

The following list of community-based organizations not only reflects the selection criteria in section b, but also an effort to identify a broad range of service agencies, including health, mental health, social services, police, courts, and legal services.

Community Organizations

Detroit Police Department
Detroit, Mich.
Contact: James Bannon

Family Violence Project
Nebraska Department of Public Welfare
Lincoln, Nebr.
Contact: Jeanne Feduck

Brooklyn Legal Services
Brooklyn, N.Y.
Contact: Marjorie Fields

Abused Women's Aid in Crisis
New York, N.Y.
Contact: Shelly Garnett

Community Effort for Abused Spouses
Mt. Vernon Center for Community Mental Health
Alexandria, Va.
Contact: Edith Hermann

Women in Transition
Philadelphia, Pa.
Contact: Andrea Ignatoff

Wife Abuse Service Center
Memphis, Tenn.
Contact: Gloria Pine

Community Health Center
Middletown, Conn.
Contact: Eileen Shekosky

York Street Center
Denver, Colo.
Contact: Katherine Sultzman

The following national organizations, task forces, and researchers also were contacted.

State or National Organizations, Coalitions and Task Forces

Rural American Women
Nashville, Tenn.
Contact: Pat Ball

South Dakota Coalition Agency
Domestic Violence and White Buffalo Calf Women's Society
Rosebud, S. Dak.

Contact: Matilda Blackbear

Center for Women Policy Studies,
Washington, D.C.
Contact: Jane Chapman

National Coalition Against Domestic Violence
Portland, Oreg.
Contact: Cynthia Dames

Western States Sherta Network
San Francisco, Calif.
Contact: Susan Hornstein

National Committee Concerned With Asian
Wives of American Servicemen
La Jolla, Calif.
Contact: Bok-Lim Kim

Center for the Pacific Asian Family, Inc.
Los Angeles, Calif.
Contact: Nilda Rimonte

University of Oregon Health Service Center
National Center for American Indian and Alaska
Natives–Mental Health Research and Development
Portland, Oreg.
Contact: Loye Ryan

Nebraska Task Force on Domestic Violence
Lincoln, Nebr.
Contact: Carolyn Schmidt

United Community Services of Metropolitan
Detroit
Researcher: Margaret Ball

Temple University
Philadelphia, Pa.
Researcher: Noel Cozenave

Content of the Telephone Consultations. The telephone discussions were intended to focus on broad subject areas. Respondents were given opportunity to discuss the following topics in detail: funding sources; barriers to obtaining Federal funding; victim needs; agency needs; the methods or practices used by the agencies, either directly, or through referral, to meet the identified needs of victims; and desired features of Federal legislation and programs that would facilitate the efforts of agencies to meet the needs of victims more effectively.

Methods of Analysis. A letter was written to each of the selected respondents describing the purposes of the consultation and indicating that project staff would make a followup telephone call to arrange for a telephone discussion. Respondents were told in the letter of the general areas in which their advice and suggestions would be sought. During the followup phone calls made by project staff members, the respondents' willingess to participate was elicited and appointments were made to follow up with another phone call that would constitute the actual discussion. None of those contacted refused to participate.

The telephone consultations were nondirective in nature. Each member of the project staff probed the responses whenever the discussion indicated the area would produce information of value. Discussions took 45–60 minutes. Staff members recorded notes of the responses in writing. The discussions yielded rich, but unstructured, information. To obtain some degree of quantification of the results for reporting purposes, the standard techniques of content analysis, as developed by Paul Lasswell and Bernard Berelson (Content Analysis, The Free Press, 1952) were utilized. This basic content analysis methodology was used to assemble all the responses from a particular content area and examine them for commonalities. The common responses were then translated into key word codes, and classified by codes. For example, one respondent might have indicated that "housing" was a key need among the victims that his or her agency was serving, while another might have said that "women need a place to stay." These answers were coded generically as "housing." Once the set of generic code responses was developed, each response was coded into a generic code category. This produced a frequency distribution of responses for each identified need. A generalized category of "other responses" was also utilized for the few, unique responses not falling into any of the major categories.

It was not possible to rank needs in their order of importance because many respondents stressed that certain needs were of equal importance; others found it necessary to differentiate among emergency, survival, and long-term needs; still others emphasized the interrelatedness of various identified needs. Therefore, the frequency of each need was coded as it was cited by the respondents.

The priority needs of victims and organizations, identified through the telephone discussions and substantiated through the literature review, were as follows:

1. *Housing.* Three types of housing needs were identified: emergency, transitional (4–6 weeks), and second stage (protected environment or an independent living situation).

2. *Mental Health.* The mental health area needs include: crisis intervention, long-term counseling, prevention, research, and training of professionals.

3. *Legal.* A range of legal services needed by victims was identified. Included were improvements in the criminal and civil justice systems; advocacy and training of attorneys, judges, police, and district attorneys; and the need for changes in legislation affecting battered women.

4. *Employment and Training and Education.* Because battered women are often housewives who have not been in the labor force, the need for education, training, and employment services to increase their employment potential and obtain a higher degree of self-sufficiency was frequently cited. These needs identified include prevocational and vocational training, employment counseling, and job placement.

5. *Financial* The financial needs identified included emergency cash assistance, as well as long-term assistance necessary until self-sufficiency can be achieved.

6. *Health.* Medical needs of battered women included emergency medical services, as well as ongoing health services such as prenatal care and nutritional services. Also included was the need for the training of health professionals.

7. *Social Services.* Social service needs overlapped some of those mentioned above such as counseling, training, legal, and financial. Also included in this category were the needs for the coordination of services, advocacy, and services to the children of abused women.

8. *Organizational Development and Management.* This category included the need to develop better planning and management capabilities to enable shelters and organizations to operate programs for battered women more efficiently.

Limitations of the Methodology Employed. The sample of 35 respondents is not a random sample of agencies providing services to battered victims in the United States. No attempt should be made to generalize nationally from these results. Rather, the data should be viewed as indicative of major concerns, needs, and views of practitioners in the field.

Federal Program Analysis

Nineteen Federal programs were analyzed to determine their relevance to meeting the needs of shelters and organizations serving victims of spouse abuse, the extent and adequacy of these programs in meeting the identified needs of shelters and organizations, and factors that promote or inhibit greater participation of shelters and organizations in these programs.

The Federal programs selected for analysis were:

- Community development block grants (entitlement/small cities) (HUD)
- Lower income housing assistance programs (Section 8) (HUD)
- Assistance payments—maintenance assistance (AFDC) (DHHS)
- Community health centers (DHHS)
- Community mental health centers (DHHS)
- Social services for low-income and public assistance recipients (Title XX) (DHHS)
- Legal Services Corporation
- Department of Defense family advocacy programs
- Comprehensive employment and training program (DOL)
- Law enforcement assistance—national priority grants program and discretionary grants programs (Department of Justice)
- Law enforcement assistance—formula grants program (Department of Justice)
- Food distribution program (Department of Agriculture)
- Community action program (CSA)
- Volunteers in Service to America (VISTA)
- Veterans Administration—hospitalization and outpatient care
- Alcohol treatment and rehabilitation programs
- Drug abuse community service programs
- Bureau of Indian Affairs social welfare program
- Donation of Federal surplus personal property (GSA)

1. *Selection Criteria.* In determining which Federal programs to select for detailed analysis, the *Catalogue of Federal Domestic Assistance* was reviewed. Information on Federal programs obtained in the telephone consultations was also considered. One hundred and eighteen Federal programs intially

were viewed as having some relevance to spouse abuse. From the 118 programs, 19 core programs were selected for detailed analysis. The following criteria were used in the selection process:

- Relevance to a major area of need;
- Amount of program dollars allocated;
- Flexibility of the use of dollars in meeting a range of needs;
- Accessibility of funding to shelters and organizations; and
- Past and current program initiatives in the area of domestic violence.

Each criterion is described below.

Relevance to a Major Area of Need. Each program selected addresses at least one of the major needs identified in the telephone consultation and literature review. Some programs that are primarily directed at one particular need have provisions that relate to other areas. For example, the community development block grant program, which is primarily a housing program, also makes funds available for community services such as day care, crime prevention, and recreation.

Amount of Program Dollars Allocated. Most of the programs selected were funded at levels above $100 million during the fiscal years examined. Those that are funded at lower levels were selected either because of their past and current activities responding to spouse abuse concerns or because of their potential to address an unmet area of need.

Flexibility. The focus of the study was to examine Federal responsiveness to the range of needs as identified in the telephone consultations and literature review. Flexibility has, therefore, been defined as the ability to respond to a broad range of needs. Although there are many ways that "flexibility" can be defined (e.g., availability of new money, no matching requirements), the above definition appeared to be most relevant to the goals of the study.

Programs were defined as very "flexible" if they possessed the capability of addressing a broad range of the identified needs (four or more). Those which addressed only one need were considered "not flexible." Programs falling in between these two extremes were considered "moderately flexible."

The range of flexibility in the core programs is as follows: very flexible—7 programs, moderately flexible—8 programs, and not flexible—4 programs.

Accessibility of funding to shelters and organizations. Some funding sources are able to provide funds directly to shelters and organizations. Other programs cannot provide funding directly, but their services are obtainable indirectly. For example, although a shelter cannot receive direct funds from VISTA, it can indirectly benefit from the services of a VISTA volunteer. Twelve programs provide direct benefits; seven provide indirect benefits.

Past and Current Initiatives. Approximately half of the core programs selected have initiated special activities directed toward assisting victims or organizations serving victims. In the remaining half, at the time of the analysis, no special efforts were evident.

Those programs in the core group that have initiated some special activities in the area of spouse abuse are as follows:

- Community development block grants
- Title XX
- Legal Services Corporation
- Department of Defense
- Comprehensive employment and training program
- LEAA—National priority and discretionary grants programs
- Community action program
- VISTA
- Alcohol rehabilitation and treatment

Tables A8 and A9 provide a graphic overview of how the core group of programs matched with the criteria for selection. In summary, programs in the core listed:

- Address all identified needs areas;
- Provide a range of flexibility;
- Reflect substantial funding;
- Reflect accessibility to shelters either directly or indirectly;
- Contain an equal mix of programs that have initiated special efforts in the area of spouse abuse and those that have not developed special initiatives.

Methods of Program Analysis. Federal liaison staff were identified in each of the relevant agencies to act as resource persons to provide general information on agency initiatives and access to sources of needed program information. Meetings were held with the Federal liasions to obtain relevant documentation, such as legislation, regulations, guidelines, financial reports, administrative directives and policy memoranda; discuss agency initiatives in spouse abuse; and to arrange for followup interviews with other relevant agency staff.

The scope of this study did not allow for field visits to local agencies to obtain information on the

effectiveness of these programs in meeting needs at the local level. Rather the focus was on how legislation, regulations, and administrative policy enable or inhibit the potential of these programs to support shelters are organizations that serve victims of violence. The assessment of programs was conducted through interviews with program staff at the Federal level and through a review of relevant program documentation.

The following outline presents the major analytic categories that served as a basis for the Federal program reviews.

Program Overview. This category included a description of the purpose and objectives of the program as stated in the authorizing legislation. It provided an orientation to the need for which the program was established and the methods of services designed to meet the program objectives.

Organizational Structure. This category included an analysis of the organizational structure of the agency responsible for administering the program, as authorized by law. Relationships and responsibilities at the Federal, State, and local levels and the nature of participation by advisory and consumer groups were also clarified.

Benefits. This category included the services that the program is authorized to provide. Restrictions on benefits, whether comprehensive or categorical, and those that are required, as opposed to those that are allowed, were analyzed.

Eligibility. Eligibility criteria for individual targets to receive the benefits, as well as restrictions on eligibility, were analyzed.

Funding. This category included the current level of funding, as compared with past and projected funding levels.

3. *Program Analysis Pretest.* To ensure that this analytical approach was efficient and most effective in eliciting high quality data, the following programs were analyzed as a pretest: Legal Services Corporations, community health centers, VISTA, food distribution program, and community development block grants (entitlement programs).

Criteria for selecting the pretest programs included size (small and large); agency representativeness (five different agencies); and activity level in domestic violence (high, medium, low).

Based on the results of the pretest, minor modifications were made in the program analysis format.

Appendix B

Federal Program Descriptions

Cash Assistance Payments: Aid to Families with Dependent Children (AFDC)

The Federal program of cash assistance payments for Aid to Families with Dependent Children (AFDC) is authorized by Title IV-A of the Social Security Act of 1935, as amended.[1] The purpose of the AFDC program is to encourage "the care of dependent children in their own homes or in the homes of relatives by enabling each State to furnish financial assistance and rehabilitation and other services to needy dependent children and the parents or relatives with whom they are living."[2] Subpurposes of the program are "to help maintain and strengthen family life" and to assist the parents or relatives of needy dependent children "to attain or retain capability for maximum self-support and independence consistent with maintenance of continuing parental care and protection" of the children.[3]

AFDC payments are made to the parent or relative of the dependent child, or to a third-party payee when it is deemed necessary.[4] The needs of the parent or relative are taken into account when determining the child's need for assistance.[5] To be eligible for cash assistance, a child must be dependent as a result of the deprivation of parental support through the "death, continued absence from the home, or physical or mental incapacity of a parent."[6]

Federal participation in the AFDC program is provided in the form of grants to States that have an approved plan for the provision of AFDC assistance.[7] Each State determines its own level of benefits to be provided to recipients, within broad guidelines provided by Federal legislation. Therefore, the levels of payments vary from State to State.

The Social Security Act provides States with the opportunity to expand the program of cash assistance for persons who may not otherwise qualify for AFDC payments by providing Federal financial participation on a matching fund basis for cash assistance programs for unemployed fathers (AFDC-UF)[8] and for emergency assistance.[9]

AFDC is a Federal entitlement program, which means that all persons who meet the eligibility requirements are entitled to receive Federal benefits under it.

[1] Codified at 42 U.S.C. §§601-611 (1976 and Supp. I 1977).
[2] 42 U.S.C. §601 (1976).
[3] *Id.*
[4] 42 U.S.C. §606(b)(1976).
[5] 42 U.S.C. §602(a)(7)(1976).
[6] 42 U.S.C. §606(a)(1976).
[7] 42 U.S.C. §601.(1976)
[8] 42 U.S.C. §607.(1976).
[9] 42 U.S.C. §§603(a)(5), 606(e)(1976).

Organizational Structure

Federal Administration

Federal administration of the AFDC program is provided by the Office of Family Assistance (OFA) within the Social Security Administration, Department of Health and Human Services (DHHS). OFA is responsible for the review and approval of State plans for the operation of the AFDC program, issuance of Federal regulations governing program administration, processing grants to the States, and maintenance of accountability systems for the State operation of the program. Individual State plans are federally administered from an OFA office in each of the 10 Federal regions.

State Administration

The Social Security Act requires each State to establish or designate a single State agency either to administer or supervise the administration of the plan for the provision of AFDC payments.[10] In either case, the State is responsible for preparing and submitting its plan.[11] Administration of the plan entails determining client eligibility for benefits, making payments to recipients, providing those services required to be included in the plan, and otherwise managing and maintaining accountability for the operation of the program.[12]

When the plan is administered by a political subdivision of the State (county), the State is responsible for the supervision of the administration of the plan.[13] In April 1978, 33 of the State AFDC plans (including the District of Columbia's) were administered by the States, and 18 were administered by political subdivisions and supervised by the State.[14]

Benefits

Federal Assistance to States

The Federal Government makes quarterly payments to States operating AFDC plans.[15] Federal payments (based on allocation formulas) provide for Federal participation in (1) meeting the costs of the cash payments made to AFDC recipients;[16] (2) meeting the costs of administering the plan for AFDC payments;[17] and (3) meeting the costs of providing emergency payments to families with needy children.[18] The Federal share of the costs of administering the State plans for provisions of AFDC payments is:

(1) 50 to 65 percent of the costs of direct ADFC payments (depending on the State);[19]

(2) 75 percent of the costs of training personnel for employment in the administration of the AFDC plan;[20]

(3) 50 percent of the costs of administering the plan;[21] and

(4) 50 percent of the costs of providing emergency financial assistance.[22]

Recipient Assistance

AFDC Cash Payments. Persons determined to be eligible under the State AFDC plan receive cash payments to assist in the care and support of a dependent child. The level of benefits provided to recipients in individual States is not based on a national standard. Rather each State sets its own "standard of need" and makes payments according to its own policies.[23] As of April 1, 1978, the maximum payment levels for a family of four (mother and three children) ranged from a low of $60 per month in Mississippi (23.81 percent of a $252 per month standard of need) to a high of $476 per month in New York (100 percent of the standard of need).[24] Of the 50 States and the District of Columbia, 20 provide payments based on 100 percent of the State's defined standard of need.[25]

Emergency Assistance. If the State AFDC plan provides for emergency assistance payments, an eligible recipient may receive benefits under the program.[26] Emergency assistance may include cash payments, loans, medical or remedial care, or ser-

[10] 42 U.S.C. §602(a)(3)(1976).
[11] 42 U.S.C. §601.(1976)
[12] For State AFDC plan requirements, see Eligibility: States, below.
[13] 45 C.F.R. §205.120 (1979).
[14] U.S., Department of Health, Education, and Welfare, *Characteristics of State Plans for Aid to Families with Dependent Children* (1978 ed.) p. vi. (hereafter cited as *State Plan Characteristics).*
[15] 42 U.S.C. §603(a)(1976).
[16] 42 U.S.C. §603(a)(1)(A)(1976).
[17] 42 U.S.C. §603(a)(3)(1976).
[18] 42 U.S.C. §603(a)(5)(1976).
[19] *State Plan Characteristics,* p. 238.
[20] 42 U.S.C. §603(a)(3)(A)(1979).
[21] 42 U.S.C. §603(a)(3)(B)(1979).
[22] 45 C.F.R. §603(a)(5)(1979).
[23] 45 C.F.R. §233.20(a)(2)(1979).
[24] *State Plan Characteristics,* pp. 236, 237. As of July 1, 1978, Mississippi raised its benefit level to $120 a month, still the lowest in the Nation. *State Plan Characteristics,* note Y, pp. 237, 234.
[25] 45 C.F.R. §233.120(1979).
[26] 45 C.F.R. §233.120(b)(2) (1979).

vices such as information, referral, counseling, assistance in securing family shelter, child care, legal services, and other services that "meet needs attributable to the emergency or unusual crisis situation."[27] A recipient is limited to emergency assistance for no more than 30 days in any 12-month period.[28] As of March 1, 1979, 21 States participated in the emergency assistance provisions of the AFDC program.[29]

AFDC for Unemployed Fathers. Where the State plan provides for participation, the dependent children of unemployed fathers who meet eligibility requirements may qualify for cash assistance payments.[30] Twenty-seven States participate in the AFDC unemployed fathers (AFDC-UF) program.[31]

Eligibility

States

In order for a State to participate in the AFDC program, it must have a plan for the operation of the program approved by the Secretary of HHS.[32] A State AFDC plan must meet Federal requirements for specific information including, but not limited to, provisions for:

(1) Statewide operation of the program: If political subdivisions of the State administer the program, the program must be mandatory for all political subdivisions;[33]

(2) Financial participation by the State in the operation of the program;[34]

(3) A single State agency either to administer or supervise the administration of the program;[35]

(4) The opportunity for a fair hearing for any individual whose claim of benefits is denied or not acted upon with reasonable promptness;[36]

(5) Methods of administration necessary for the proper and efficient operation of the program;[37]

(6) State agency compliance with requests for reports made by HHS;[38]

(7) The determiniation of need, by taking into consideration the income or resources of all persons (living in the same household as a dependent child) whose needs the State determines should be considered in determining the need of the dependent child. This includes expenses reasonably attributable to the earning of any income;[39]

(8) The exclusion of all income of a dependent child who is a full-time or a part-time student not employed full-time. Where a dependent child is not a student, and in the case of all other persons, the first $30 of earned income, plus one-third of the remainder, shall be excluded when determining earned income. The earned income of a person who, without good cause, terminated his or her employment or refused to accept a job or job training shall not be excluded;[40]

(9) Safeguards to protect the confidentiality of information about applicants or recipients of benefits;[41]

(10) An opportunity for all persons desiring to do so to make an application for assistance and to be notified of their eligibility with reasonable promptness;[42]

(11) Notification to the State child support collection agency of the provision of benefits to a child who has been deserted or abandoned by a parent;[43]

(12) The development of a program of family planning services to be made available to benefit recipients, on a voluntary basis;[44]

(13) The reporting of suspected instances of child neglect, abuse, or exploitation to the appropriate authorities;[45]

(14) The registration of all eligible recipients for manpower services, as a condition of eligibility; a refusal to register, without good cause, is a basis for denial of eligibility for any applicant above the age of 16 years;[46]

(15) The exclusion of the income and resources of medical assistance (medicaid), when determining family need;[47]

[27] 45 C.F.R. §233.120(b)(3)(1979).
[28] U.S., Department of Health, Education, and Welfare, *Public Assistance Statistics:* March 1979, p. 15.
[29] 42 U.S.C. §607 (1976).
[30] *Public Assistance Statistics: March 1979,* p. 11 (1976).
[31] 42 U.S.C. §601 (1976).
[32] 42 U.S.C. §602(a)(1)(1976).
[33] 42 U.S.C. §602(a)(2)(1976).
[34] 42 U.S.C. §602(a)(3)(1976).
[35] 42 U.S.C. §602(a)(4)(1976).
[36] 42 U.S.C. §602(a)(5)(1976).
[37] 42 U.S.C. §602(a)(6)(1976).
[38] 42 U.S.C. §602(a)(7)(1976).
[39] 42 U.S.C. §602(a)(8)(1976).
[40] 42 U.S.C. §602(a)(9)(1976).
[41] 42 U.S.C. §602(a)(10)(1976).
[42] 42 U.S.C. §602(a)(11)(1976).
[43] 42 U.S.C. §602(a)(15)(1976).
[44] 42 U.S.C. §602(a)(16)(1976).
[45] 42 U.S.C. §602(a)(19)(1976).
[46] 42 U.S.C. §602(a)(24)(1976).
[47] 42 U.S.C. §602(a)(25)(1976).

(16) Each applicant or recipient's furnishing of his or her social security number as a condition of eligibility;[48]

(17) Each applicant or recipient's assignment to the State agency of any rights to support from another person, which are in effect at the time of their declaration of eligiblity;[49]

(18) A State plan for the operation of a child-support payments collection unit;[50]

(19) Each applicant's and recipient's cooperation with the State agency in determining the paternity of a dependent child born out of wedlock, as a condition of eligibility;[51] and

(20) The supplementation of client benefits with any child support payments collected, as long as the amount of the payments does not reduce the amount of the assistance grant provided.[52]

Recipients

AFDC Cash Assistance Payments. To be eligible for AFDC cash assistance payments, an applicant must meet the following requirements:

(1) Be a citizen of the United States or an alien lawfully admitted for permanent residence or otherwise lawfully residing in the United States on a permanent basis;[53]

(2) Be a child under the age of 18, or dependent under the age of 21 if regularly attending school,[54] deprived of parental support or care by reason of the death, continued absence from the home, or mental or physical incapacity of a parent, and who is living in the home of a parent or relative (grandparent, brother, sister, steparent, stepbrother stepsister, uncle, aunt, first cousin, nephew, or niece), and maintained by such relative(s) as his or her own home;[55] or

(3) Be a parent or relative of a dependent child, as specified in (2) above;[56]

(4) Must register for manpower training, or accept employment if it is offered: if above the age of 16 and not attending school (age 21 if attending school) or mother (or other caretaker) of a child under age 6;[57]

(5) Must assign to the State agency any rights to support from another person;[58]

(6) Must cooperate with the State agency in establishing the paternity of an eligible dependent child;[59]

(7) Must furnish the State agency his or her social security number and other forms of data as required as a means of identification;[60]

(8) Must not have real or personal property, including liquid assets, with a total value of more than $2,000 (excluding a home, personal effects, automobile and any income-producing property allowable by the agency);[61]

(9) Must not have total income and resources that exceed the State standard of need, after the exclusion of specified income (see items 7 and 8 under State eligibility above).[62]

Emergency Assistance. Where the State AFDC plan provides for participation in the emergency assistance program, an applicant must be a needy child under age 21, or any other member of the household in which he or she is living, if:

(1) The child has been living with a parent or relative within the past 6 months;

(2) The child is without resources to meet his or her needs;

(3) The emergency assistance is necessary to avoid destitution of the child or to provide living arrangements for him or her in a home; and

(4) The child's destitution or need for living arrangements did not arise because he, she, or such relatives refused without good cause to accept employment or job training.[63]

AFDC for Children of Unemployed Fathers. When the State plan provides for participation in the AFDC program for dependent children of unemployed fathers, an applicant must meet the following eligibility requirements:

(1) Be a dependent child who, regardless of any other definition, has been deprived of parental support and care because of the unemployment of his or her father and who is living with any of the relatives specified under AFDC Cash Assistance

[48] 42 U.S.C. §602(a)(26)(A)(1976).
[49] 42 U.S.C. §602(a)(27)(1976 and Supp. I 1977).
[50] 42 U.S.C. §602(a)(26)(B)(1976).
[51] 42 U.S.C. §602(a)(28)(1976 and Supp. I 1977).
[52] 45 C.F.R. §233.50 (1979).
[53] 42 U.S.C. §606(a)(2)(1976).
[54] 42 U.S.C. §606(a)(1)(1976).
[55] 42 U.S.C. §606(b)(1976).
[56] 42 U.S.C. §602(a)(19)(1976).
[57] 42 U.S.C. §602(a)(26)(A)(1976).
[58] 42 U.S.C. §602(a)(26)(B)(1976).
[59] 42 U.S.C. §602(1976).
[60] 45 C.F.R. §233.20(a)(3)(1979).
[61] 45 C.F.R. §233.20(1979).
[62] 45 C.F.R. §233.120(b)(1)(1979).
[63] 42 U.S.C. §607(a)(1976).

Payments above; and has a father who must have been unemployed for at least 30 days prior to the receipt of benefits;[64] must not have refused a job offer within the previous 30 days;[65] and has been employed 6 or more quarters (24 months) in any 13-quarter calendar period (52 months) ending within 1 year prior to the application for aid, or has received unemployment compensation within 1 year prior to the date of application for aid.[66]

Funding

The budget request for FY 80 included $6.29 billion for AFDC cash payments, $44.1 million for emergency assistance, and $721.0 million for State and local administration.[67]

[64] 42 U.S.C. §607(b)(1)(A)(1976).
[65] 42 U.S.C. §607(b)(1)(B)(1976).
[66] 42 U.S.C. §607(b)(1)(C)(1976).
[67] Department of Health, Education and Welfare, "FY 1980 Justification of Appropriations Estimates for Committee on Appropriations: Social Security Administration," working paper, March 1979, p. 84.

Bureau of Indian Affairs Social Welfare Programs

The social welfare programs of the Bureau of Indian Affairs (BIA) are authorized by chapter 115 of the Snyder Act of 1921,[1] as amended.[2] Chapter 115 mandates BIA to "direct, supervise, and expend funds," appropriated by Congress, "for the benefit, care, and assistance" of Indians throughout the United States.[3] The BIA carries out these requirements through its social welfare programs and many other programs. The BIA social welfare programs are: child welfare assistance, family and community services, general assistance, and miscellaneous assistance.[4] The BIA will only provide these services to eligible Indians on or near reservations in areas which such services are not already available through State, local, or other welfare agencies.[5] Services provided by BIA on Indian reservations are required, as much as possible, to be consistent with tribal customs, codes, and laws.[6]

Organizational Structure

Indian social welfare programs are administered by the Division of Social Services, Office of Indian Services, Bureau of Indian Affairs, within the U.S. Department of the Interior. BIA has 12 regions; the Division of Social Services maintains social work staffs in 11 of these regions. At the local level, services and assistance are provided through 79 agency offices located on or near Indian reservations.[7] Direct services are provided through the agency offices.

Since BIA social welfare programs are only provided where similar services are not otherwise provided or available to Indians, these programs are available in only 15 States: Alaska, Arizona, Colorado, Idaho, Minnesota, Mississippi, Montana, Nebraska, North Carolina, North Dakota, Nevada, New Mexico, Oklahoma, South Dakota, and Wyoming. Effective July 1, 1980, BIA social welfare programs were made available to Indians living on or near reservations in the State of Maine.[8]

Benefits

Social welfare program benefits are available in the following areas:

Child Welfare Assistance. This program provides cash payments for the maintenance of eligible Indian children in foster care settings.[9]

Family and Community Services. Eligible Indians may receive family and community services that include, but are not limited to, the following:[10]

(1) Family and individual counseling to assist in solving problems related to family functioning, housekeeping practices, care and supervision of children, interpersonal relationships, economic opportunity, money management, and problems related to illness, physical or mental handicaps, drug abuse, alcoholism, and violation of the law.

(2) Protective services that are provided when children or adults are deprived temporarily or permanently of needed supervision by responsible adults or are neglected, exploited, or need services when they are mentally or physically handicapped or otherwise disabled, and for children who have run away from home. Such services may include but are not limited to the following:

(a) Response to requests from members of the community on behalf of children or adults alleged to need protective services.

(b) Family and supplemental services, including referral for homemaker and day care services, which appropriately divert children from the juvenile justice system.

(c) Services to responsible family members or guardians to seek appropriate court protections for the child or adult, to seek the appointment of a guardian.

(3) Services to Indian courts, which may include but are not limited to the following:

(a) Investigations and reports as to allegations of child and adult abuse and neglect, abandonment, delinquency, running away from home, and conditions such as mental or physical handicaps or otherwise being disabled.

[1] 42 Stat. 208; 25 U.S.C. §13 (1976).
[2] 25 U.S.C.A. §13 (Supp. 1979).
[3] 25 U.S.C. §13 (1976).
[4] 25 C.F.R. §20.22a; 20.24(a)(b)(1)(2);20.21(a)(b)(c); 20.23 (1979).
[5] *Id.* §20.3.
[6] *Id.* §20.25.
[7] Raymond Butler, telephone interview, Washington, D.C. Dec. 12, 1979 (hereafter referred to as Butler Interview).
[8] Ibid.
[9] 25 C.F.R. §20.24(4)(1979).
[10] *Id.* §20.24(b)(1)(2)(3)(4)(5)(6).

(b) Provisions of social information related to the disposition of a case, including evaluation of alternative sources of treatment.

(c) Provision of services requested by the court before adjudication such as family counseling and child custody, and after adjudication such as probation, foster care, and supervision of children and adults in their own homes.

(4) Foster care services for children that shall be provided when an Indian child is a recipient of child welfare assistance and services are not available from another source, and may be provided as needed for an Indian child living away from her or his parent(s) in the absence of a child welfare assistance payment. Such services shall include but are not limited to:

(a) Determination that foster care is the best available plan for the child.

(b) Development of an immediate and long-range plan to establish a more stable emotional and social life for the child and her or his family, including referral of the child for adoption when indicated.

(c) Services in the recruitment and development of suitable foster homes and other foster care facilities.

(d) Services to responsible family members, or at the request of an Indian court having jurisdiction, in the selection of a suitable foster care facility and a continued evaluation of the suitability of the facility.

(e) Services in the placement of an Indian child for long- or short-term foster care suited to her or his needs and to review the plan periodically.

(f) Services to parent(s), foster parent(s), or other caretaker(s) to provide care and guidance for the child in foster care.

(5) Foster care services for adults which are to be provided when a general assistance payment is made for their care in a foster care facility, or when needed in the absence of a general assistance payment. The services may include but are not limited to:

(a) Arranging for care in a private family home or in a facility for the aged or disabled except where the primary service provided by the facility is medical.

(b) Services to responsible family members, guardians, or at the request of an Indian court having jurisdiction, in selecting a facility that will provide needed care.

(c) Services providing for continuity with family and community ties.

(d) Services for continuing evaluation of the suitability of the facility selected, including referral for other care as indicated.

(6) Community services involving other groups, agencies, and facilities, which may include but are not limited to:

(a) Responses to community needs for evaluating social conditions that are within the competence of social services.

(b) Treatment of the identified conditions that are within the competence of social services.

(c) Maintenance of a liaison relationship with other community agencies for the purpose of identifying the availability of services that may be used to assist in solving the social problems of individuals, families, and children, or facilitating the use of available community services by Indian persons who need them.

General Assistance. Eligible Indians may receive general assistance (cash payments) if they do not otherwise qualify for the cash assistance program under the Social Security Act.[11]

Miscellaneous Assistance. Eligible Indians may receive miscellaneous assistance benefits, which are "financial payments made for burial services, to facilitate the provision of emergency food or disaster programs, or for other financial needs. . .not provided for by other BIA social welfare programs, but related to assistance for needy Indians."[12]

Eligiblity

General Eligiblity Requirements

To be eligible for benefits from BIA social welfare programs an applicant must be an Indian, except that in the States of Alaska and Oklahoma a one-fourth degree or more Indian blood will be an additional eligiblity requirement; must reside on or near a reservation; and must meet the specific welfare program for which application is made.[13]

[11] *Id.* §20.1(m), 20.21(b)(c).

[12] *Id.* §20.1(g).

[13] *Id.* §20.20.

Eligiblity Requirements for Specific Programs

Child Welfare Assistance. If an Indian child meets the general eligibility requirements, then she or he is eligible for child welfare assistance if all the following conditions apply:

- The child's legally responsible parent, guardian, or Indian court having jurisdiction requests assistance and is unable to provide necessary care and guidance for the child in her or his own home for other than financial reasons and is unable to meet the cost of foster care, and is unable to provide for the special needs of the child through other BIA assistance programs, including general assistance.
- The child is not receiving and is not eligible to receive assistance under the case assistance programs of the Social Security Act.
- The child resides in an area where comparable assistance is unavailable or is not being provided to all residents on the same basis by a State, county, or local government.[14]

Family and Community Services. Family and community services may be provided to persons meeting the general eligibility requirements for services, who request such services, or for whom such services are requested.[15]

General Assistance. Indians meeting the general eligibility requirements may receive general assistance payments if:[16]

- Their available resources (income and services) do not meet their needs.
- They do not receive, or are not eligible to receive, benefits under the cash assistance programs of the Social Security Act.
- They reside in areas where comparable general assistance is unavailable or not being provided to all residents on the same basis from a State, county, or local welfare agency.
- They accept available employment that they are able and qualified to perform.

Miscellaneous Assistance. Miscellaneous assistance payments may be made to persons meeting the general eligiblity requirements for services, provided they reside in an area where comparable assistance is unavailable or is not being provided to all residents on the same basis by a State, county, or local government.[17]

Application Process

Applications for BIA social welfare programs are made directly to BIA staff at an agency office. Either oral or written applications are acceptable.[18] Additionally, third parties may make applications on behalf of needy applicants.[19] Applicants themselves serve as the primary source of information regarding their circumstances and needs. Information about the applicant's circumstances cannot be ontained from other sources without the applicant's authorization.[20]

A decision approving or denying the applicant's eligibility must be made within 30 days of the date of the application. If a decision is not made within that time, the applicant must be notified in writing as to the reasons for the delay. In no case can a decision be delayed for a period of more than 45 days from the date of the application. Decisions denying an application for benefits can be appealed to BIA within 20 days of the decision date.[21]

Funding

For fiscal year 1980 the budget request for Indian social welfare programs was $74,305,000.[22] The amount represents a 5 percent decrease from fiscal year 1979 appropriations, adjusted for inflation.

[14] *Id.* §20.22(a)(b)(c).
[15] *Id.* §20.24(a).
[16] *Id.* §20.21(a)(b)(c)(d).
[17] 25. C.F.R. §20.23.
[18] *Id.* §20.10(a)
[19] *Id.*
[20] *Id.* §20.11(a).
[21] *Id.* §20.12(a)(3).
[22] Butler Interview.

Donation of Federal Surplus Personal Property to Public Agencies and Nonprofit Educational and Public Health Institutions and Organizations

The program for donation of Federal surplus personal property to public agencies and nonprofit educational and public health institutions and organizations is authorized by section 203(j) of the Federal Property and Administrative Services Act of 1949,[1] as amended.[2] The act authorizes the Administrator of the General Services Administration (GSA) to transfer Federal surplus personal property to the States for donation to State and local public agencies or to certain nonprofit educational or public health institutions or organizations.[3] Examples of the types of property donated through the program include office machines, office supplies, furniture, household goods, and cafeteria equipment.[4]

Organizational Structure

Federal Administration

Federal surplus personal property donation programs are administered by the Office of Personal Property Disposal in the Federal Property Resource Service of the General Services Administration. Overall administration is provided by GSA headquarters in Washington, D.C., with administration of the programs for individual States being provided by a GSA office in each of the Federal regions.[5]

The Federal administration activities consist of determining property eligible for transfer to the States, allocation and transferring property to the States and regulating State plans for the acquisition and distribution of tranferred property.[6]

State Administration

State surplus property agencies have been established in the 50 States, the U.S. territories, and the District of Columbia. These agencies can be identified by consulting the "State Government" listings in the telephone book or the GSA pamphlet, "Federal Surplus Property Donations Programs."

Benefits

The Federal surplus personal property program authorizes the Administrator of GSA to transfer property designated as "surplus" to State surplus property agencies.[7] The only cost to the State for this is for care and handling.[8]

Upon receipt of the property from GSA, the State agency is authorized to donate it to public agencies and nonprofit educational or public health institutions or organizations.[9] Examples of nonprofit educational or public health institutions or organizations are "medical institutions, hospitals, clinics, health centers, schools, colleges, universities, schools for the mentally retarded, schools for the physically handicapped, child care centers, radio and television stations licensed by the Federal Communications Commission as educational radio or educational television stations, museums attended by the public, and libraries serving free all residents of a community, district, State, or region."[10]

In allocating and transferring surplus property, the GSA Administrator is required to give special consideration to eligible recipients' expressions of need for and interest in specific items.[11] The types of personal property subject to transfer and subsequent donation are not limited by either legislation or administrative regulations. However, the State agency may impose a service charge on the donation to cover the direct and reasonable indirect costs of screening, packing, crating, removal, and transportation;[12] or the agency may impose reasonable terms, conditions, reservations, and restrictions on the use of donated property, and it is required to impose

[1] 40 U.S.C. §484(j) (1976).
[2] Act of Sept. 5, 1950, ch. 849, §4, 64 Stat. 579; Act of June 3, 1955, Ch. 130, §§1, 2(a), 6, 69 Stat. 83; Act of July 3, 1956, Ch. 513, §1, 70 Stat. 493; Pub. L. 87-786, 76 Stat. 805; Pub. L. 94-519, §1, 90 Stat. 2451; codified in 40 U.S.C. §484(j).
[3] *Id.* §484(j)(2)(A)(B).
[4] U.S., General Services Administration, *Federal Surplus Personal Property Donations Programs* (1977), p. 1; Raymond Shepard, General Services Administration, telephone interview in Washington, D.C., Nov. 2, 1979 (hereafter cited as Shepard Interview).
[5] *Id.*
[6] 48 U.S.C. §484(j).
[7] *Id.*(1).
[8] *Id.*
[9] *Id.*(3)(A)(B).
[10] *Id.*
[11] *Id.*
[12] *Id.*

such conditions or restrictions in the case of any motor vehicle donated, or any item of property having an acquisition cost of $3,000 or more.[13] The recipient of donated property may also request direct shipment.[14]

When donated property has not been put to the use for which it was donated within a period of 1 year, it must be returned to the State agency in usable condition for further donation.[15]

Eligibility

State Surplus Property Agency

To be eligible for participation in the Federal surplus personal property donation program, a State must have an agency (designated by State law) responsible for the fair and equitable distribution of surplus property transferred from GSA.[16] The designated State surplus property agency must submit a detailed plan for the operation of the program to the Administrator of the GSA for approval.[17]

The State plan must include the following:

(1) Details of the inventory and accounting system used in managing the program.[18]

(2) Requirements for the return of donated property that is not used for the purpose for which it was donated within 1 year from the date of donation.[19]

(3) Specification of the means and methods of financing the State agency. If the agency assesses service charges to cover the direct and indirect costs of its operations, it must specify the method of calculating those costs.[20]

(4) Specific terms, conditions, reservations, and restrictions to be imposed on use of property with an acquistion value of $3,000 or more and on any passenger motor vehicle. Additionally, any terms, conditions, etc. to be imposed on the use of other donated property must be specified.[21]

(5) Provisions for disposal of unused donable property.[22]

(6) Provisions for fair and equitable distribution of transferred property, based on the relative needs and resources of eligible donees and their ability to use the property. Additionally, there must be provisions for the agency, insofar as practicable to select property requested by eligible donees and, when requested, arrange for direct shipment.[23]

(7) Procedures for the determination of eligible donees in accordance with the standards and guidelines specified in 41 C.F.R. §101–44.207.[24]

(8) Procedures to be used in utilization reviews of donees' compliance with the terms, conditions, etc. imposed on the use of donated property. Additionally, the time frames for such reviews, the means of seeking compliance, and assurances that instances of alleged fraud or misuse of donated property will be reported to the appropriate authorities must be included.[25]

(9) Requirements for the agency's consultation with advisory bodies and public and private groups that can assist the agency in determining the relative needs and resources of donees, the utilization of donable property by donees, and how the distribution of donable property can be effected to fill existing needs of donees. The details of how such consultations will be established must also be included.[26]

(10) Provisions for periodic internal and external audits of the operations and finances of the agency.[27]

Recipients

Recipients of donated surplus Federal property are limited to public agencies and nonprofit educational or public health institutions or organizations.[28] Nonprofit agencies must have tax-exempt status under section 501 of Title 26 of the Internal Revenue Service Code.[29]

Property donated through the program must be used essentially for the primary educational or public health function of the eligible donee, and not for an unrelated or commercial purpose.[30] Determination of the eligibility of nonprofit institutions and

[13] *Id.*
[14] *Id.*
[15] *Id.*
[16] *Id.*
[17] *Id.*
[18] 41 C.F.R. §101–44.202(c)(3).
[19] *Id.* (c)(4).
[20] *Id.* (c)(5).
[21] *Id.* (c)(6).
[22] *Id.* (c)(7).
[23] *Id.* (c)(8).
[24] *Id.* (c)(9).
[25] *Id.* (c)(10).
[26] *Id.* (c)(11).
[27] *Id.* (c)(12).
[28] 40 U.S.C. 3484(j)(3)(B)(1976).
[29] *Id.*
[30] 41 C.F.R. §101–44.207(d)(1979).

organizations is a function of the State surplus property agency,[31] and the agency has limited discretion to determine eligibility within the guidelines specified in 41 C.F.R. §101–44.207.

Administration regulations define the term "educational institution" as:

> An approved, accredited, or licensed public or nonprofit institution, facility, entity, or organization conducting educational programs, including research for any such programs, such as a child care center, school, college, university, school for the mentally retarded, school for the physically handicapped, or an educational radio or television station.[32]

The term "public health" is defined as:

> A program or programs to promote, maintain, and conserve the public's health by providing health services to individuals and by conducting research, investigations, examinations, training, and demonstrations. Public health services may include but are not limited to the control of communicable disease, immunization, maternal and child health programs, sanitary engineering, sewage treatment and disposal, sanitation inspection and supervision, water purification and distribution, air pollution control, garbage and trash disposal, and the control and elimination of disease-carrying animals and insects.[33]

Each prospective recipient must submit an application containing the following information:[34]

- The legal name and address of the applicant.
- Evidence of nonprofit status under section 501 of the Internal Revenue Code.
- Details of the applicant's activities, showing compliance with the public agency, educational institution, or public health requirements of the property donation program.
- Evidence that the applicant is appropriately approved, accredited, or licensed as may be appropriate.

In addition to the formal application, a written authorization from the appropriate organization executive must be submitted designating an individual to act on behalf of the organization in acquiring donated property (with authority to obligate funds for the acquisition).[35] Assurances that the organization does not discriminate against persons in the operation of its programs must also be provided.[36]

Additionally, the State agency may require the organization to submit statements of its need for donated property and of its current resources (including financial status).[37] A recipient eligibility file must be updated at least once every 3 years.

If an organization has been recently established, the State agency may grant conditional eligibility for the receipt of donated property.[38]

Funding

The only Federal appropriation for the donation of surplus personal property program is to pay administrative salaries and expenses. The Federal administrative costs for fiscal year 1978 were $6,073,000 and were estimated to be $7,202,000 for fiscal year 1979.[39]

The original acquisition cost of property donated under all Federal surplus property programs[40] in fiscal year 1978 was $483 million.[41]

[31] *Id.*
[32] *Id.*
[33] *Id.*
[34] *Id.*
[35] *Id.*
[36] *Id.*
[37] *Id.*
[38] *Id.*

[39] *Federal Catalogue of Domestic Assistance*, item 39.003, p. 759.
[40] Other surplus personal property donation programs authorized under 40 U.S.C. §484 provide for the donation of property for educational activities of special interest to the armed services (40 U.S.C. §484(j)(2) and to the American Red Cross (40 U.S.C. §484(1)). Additionally, 50 U.S.C. 1622(b) provides for the transfer of personal property to airports.
[41] Shepard Interview.

Lower Income Housing Assistance Payments Program (Section 8)

Title II, "Assisted Housing," of the Housing and Community Development Act of 1974, substantially amended the United States Housing Act of 1937.[1] This title included the declaration that:

> It is the policy of the United States to promote the general welfare of the Nation by employing its funds. . .to assist the several States and their political subdivisions to remedy the unsafe and unsanitary housing conditions and the acute shortage of decent, safe, and sanitary dwellings for families of low income and. . .to vest in local public housing agencies the maximum amount of responsibility in the administration of their housing programs. . . .[2]

Section 8 of this title establishes the lower income housing assistance programs in the Department of Housing and Urban Development (HUD). The purpose and approach of the section 8 program are described in paragraph (a), which states:

> For the purpose of aiding lower income families in obtaining a decent place to live and of promoting economically mixed housing, assistance payments may be made with respect to existing, newly constructed, and substantially rehabilitated housing in accordance with the provisions of this section.[3]

The section 8 program, as described in HUD's 1980 budget justification, is "the major HUD program for providing federally assisted rental housing."[4] It consists of four distinct major programs: existing housing, new construction, substantial rehabilitation, and moderate rehabilitation. The purpose of these programs is to assist lower income families in paying for decent, safe, and sanitary housing. In the existing housing program, the eligible family is responsible for selecting a unit in the housing market, and the owner of the unit is paid for the difference between the unit's rent and what the family can afford. In the new construction, substantial rehabilitation, and moderate rehablitation programs, the owner contracts in advance of construction with the local public housing authority or HUD to make a percentage of the units in the building available to lower income families in return for assured rent for these units. This contract can be used as security in financing the project. In other words, the Federal assistance stays with the *family* in the existing housing program and with the housing unit in the new construction, moderate rehabilitation, and substantial rehabilitation programs.[5]

Organizational Structure

The Department of Housing and Urban Development (HUD) is responsible for administering the section 8 program by entering "into annual contributions contracts with public housing agencies. . .to make assistance payments to owners of existing dwelling units."[6] The Department is administered by the HUD Central Office through 10 regional offices and 50 area offices. The regional offices exercise fiscal and administrative, but not programmatic supervision of the area offices. The area offices are responsible for programmatic and funding decisions, under the supervision of the HUD Central Office program staff.[7]

The area offices, or field offices as they are sometimes called, exercise their programmatic responsibilities through contracts with local public housing authorities (PHAs).[8] Although most urban areas have PHAs, this is not the case in all locales. Some State governments have established a housing agency which can act as a PHA for areas lacking one.[9] When there is neither a State nor local PHA serving an area, HUD is authorized to serve in that capacity and administer the program directly; in

[1] Pub. L. No. 93-383, §201(a), 88 Stat. 633, as amended by Pub. L. No. 92-128, 91 Stat. 1111.

[2] Pub. L. No. 93-383, §201(a), 88 Stat. 633, amending 42 U.S.C. §1437 (1976).

[3] Section 8 is now codified at 42 U.S.C. §1437f (1976).

[4] U.S., Department of Housing and Urban Development, *Justification for 1980 Estimates* (March 1979), part 1, p. C-8 (hereafter cited as *FY 80 Budget Justification).*

[5] Richard Finkleman, housing program officer, section 8, Moderate Rehabilitation and Existing Housing Division, Department of Housing and Urban Development, interview in Washington, D.C., Dec. 3, 1979 (hereafter cited as Finkleman Interview).

[6] 42 U.S.C. §1437f(b)(1)(1976).

[7] 24 C.F.R. §880.201, §881.201, §882.201(1979); Finkleman Interview; Madeline Gold and Helen Helfer, program analysts, Office of Women's Policy and Programs, Office of Assistant Secretary for Neighborhoods, Voluntary Associations and Consumer Protection, Department of Housing and Urban Development, interview in Washington, D.C., Dec. 3, 1979 (hereafter cited as Gold Interview).

[8] 24 C.F.R. §880.201, §881.201, §882.201(1979); Finkleman Interview; Gold Interview.

[9] Finkleman Interview; 24 C.F.R. §882.121 (1979); 42 U.S.C. §1437 f(b)(1)(1976).

practice, however, this does not occur because of the lack of funds to provide adequate staff in these instances.[10] In Maryland, for example, Baltimore County and several rural counties do not have PHAs, but the State has an agency that serves in that capacity and, through private contractors, manages the section 8 program for these areas.[11] In contrast, several counties in Arizona do not have PHAs and the State has not established an agency to provide services to them. Since HUD is unable to provide the necessary management services, these counties do not participate in the section 8 programs.[12]

Benefits

The four major section 8 programs, existing housing, new construction, and moderate and substantial rehabilitation[13], are administered as two programs, with new construction and substantial rehabilitation being treated together.

Existing Housing and Moderate Rehabilitation

The law provides that HUD may enter into contracts with the PHA to make assistance payments to owners of existing dwelling units, meeting applicable standards, that may then be rented to eligible families.[14] These payments cover the difference between the contract rent of the unit, as established and adjusted annually by HUD, and 15 to 25 percent of the family's income, depending upon family size, income, and expenses.[15]

To receive assistance under the existing housing program, a family must apply to the PHA for a certificate of family participation. The PHA is responsible for determining the family's eligibility and amount of assistance that the family can receive by verifying the sources of family income and other necessary information.[16] If the family is eligible and a certificate is available, the family (depending on housing availability) is issued a certificate for assistance in renting the smallest unit consistent with the following criteria:

- No more than two persons must share a bedroom;
- Other than spouses and very young children, persons of opposite sex need not share a bedroom;
- Single-person households are assigned a no-bedroom unit (e.g., "efficiency" apartment) if such units are included in the local program or a one-bedroom unit if they are not; or
- HUD-approved variations on these criteria, as requested by PHAs because of unique or market conditions.[17]

Once a family has obtained a certificate, it then is responsible for finding its own acceptable unit in the free market. Under the "finders-keepers policy," a family may use the certificate for rental assistance in the housing unit it currently occupies, if that unit qualifies as existing housing.[18] Although the certificate specifies the unit size for which the family is eligible, if it can find a larger unit within the approved rent for its family size and composition, the larger unit "shall not be disapproved."[19]

Similarly, if a family selects a unit for which the rent is lower than the approved "fair market rent," it will receive a reduction in the gross family contribution it makes for its housing costs. This "rent credit" program was discontinued by HUD on October 9, 1980, because in most instances it has been used only by families already living in suitable units who remain in them under the program.[20] It has apparently not encouraged families in unacceptable units to shop around, as intended when the program was established.[21]

When a family has found a unit it wants to lease and has negotiated successfully with the owner, it submits a signed request for a lease approval with a copy of the proposed lease to the PHA. The PHA then reviews the lease and determines if the rent is appropriate and all other conditions are met. The PHA also inspects the unit for compliance with its housing quality standards. If there are no deficiencies in the unit that require correction, the lease is approved. If corrections are required, they must be made before the PHA can contract with the owner.[22] To qualify, a housing unit must meet housing quality standards imposed by HUD or, if local conditions or codes necessitate, as modified by the

[10] Ibid.
[11] Finkleman Interview.
[12] Ibid.
[13] 42 U.S.C. §1437f(a)(1976); 24 C.F.R. §§880, 881, 882 (1979).
[14] 42 U.S.C. §1437f(b)(1) (1976).
[15] 42 U.S.C. §1437f(c)(3) (1976).
[16] 24 C.F.R. §882.209(a)(1) (1979).
[17] 24 C.F.R. §882.209(a)(2) (1979).
[18] 24 C.F.R. §882.103(a) (1979).
[19] 24 C.F.R. §882.210(e) (1979).
[20] Letter to Louis Nunez from Clyde McHenry, Deputy Assistant Secretary for Housing, HUD, Oct. 24, 1980.
[21] Finkleman Interview.
[22] 24 C.F.R. §882.210(d)(2) (1979).

PHA with HUD approval. These standards include reference to sanitary facilities, food preparation and refuse disposal, space and security, thermal environment, illumination and electricity, structure and materials, interior air quality, water supply, lead-based paint, access, site and neighborhood, and sanitary conditions.[23] Slightly different standards apply to "congregate housing" and "independent group residences," which are primarily intended for disabled or frail, elderly individuals.[24]

HUD has recently instituted the moderate rehabilitation program to upgrade existing housing that is marginally deteriorated. At present, owners invest an average of approximately $400 in repairs to a unit before it is approved.[25] To increase the number of available units under the moderate rehabilitation program, the PHA may authorize up to 120 percent of the existing housing fair market rent[26] for units in buildings where the owners invest at least $1,000 per unit in repairs. Although routine maintenance such as painting does not qualify, if the unit is substandard, has substantial deferred maintenance, or if major building systems, such as the furnace, are expected to become substandard within 2 years, the building may qualify for this program.[27] Tenants are selected from the waiting list for existing housing.[28]

New Construction and Substantial Rehabilitation

The law authorizes HUD and PHAs "to make assistance payments pursuant to contracts with owners or prospective owners who agree to construct or substantially rehabilitate housing in which some or all of the units shall be available for occupancy by lower income families."[29]

New construction and substantial rehabilitation projects are permitted only where there is an inadequate supply of existing housing or the project is in accord with priorities established by the Secretary of HUD.[30] In selecting projects for support under these programs, preference is given to projects that limit the number of section 8 units in the project to 20 percent or less of the total units. This is done to help achieve the statutory goal of "promoting economically mixed housing." However, HUD *can* support projects in which up to 100 percent of the units are included in the section 8 contract.[31] Preference is also given to proposals that provide units with three or more bedrooms to encourage the availability of housing for large families.[32]

Before construction or rehabilitation of the units, HUD and the owner must agree on a percentage of the units in the project to be set aside for section 8 eligible families. This contract is for 20 years for privately owned projects and up to 40 years for family projects owned or financed by a State or local agency and in an area designated by HUD or requiring special financial assistance.[33] The contracts include a commitment by HUD to provide housing assistance payments that "cover the difference between the contract rent and the portion of said rent payable by the family"[34] for units leased to eligible families. The owner receives 80 percent of the contract rent for vacant units during the initial "rent-up" period or when a unit is vacated by an eligible family, if the owner "has taken. . .all feasible actions to fill the vacancy."[35] If the unit remains vacant after 60 days, the owner may receive semiannual payments equal to that portion of the principal and interest on the mortgage attributable to the vacant unit, for a period up to 12 months, if the unit complies with HUD standards and the owner continues attempting to fill it.[36] The owner may use the HUD contract as security for obtaining financing for construction or rehabilitation of the unit.[37]

The owner, rather than HUD, is responsible for providing all management and maintenance of the project, including:

- Payment of utilities, services, insurance, and taxes.
- Ordinary and extraordinary maintenance.

[23] 24 C.F.R. §882.109 (1979).
[24] 24 C.F.R. §882.109(m), (n); §882.110(b).
[25] Mary Maher, housing program officer, section 8, Moderate Rehabilitation and Existing Housing Division, Department of Housing and Urban Development, telephone interview in Washington, D.C., Dec. 4, 1979 (hereafter cited as Maher Interview).
[26] 44 Fed. Reg. 26660, 26673 (1979) (to be codified in 24 C.F.R. §882.409).
[27] 44 Fed. Reg. 26660, 26670 (1979) (to be codified in 24 C.F.R. §882.402).
[28] 44 Fed. Reg. 26660, 26683 (1979) (to be codified in 24 C.F.R. §§882.516, 882.517).
[29] 42 U.S.C. §1437f(b)(2)(1976).
[30] 24 C.F.R. §880.103, §881.103 (1979).
[31] 24 C.F.R. §880.104(a), §881.104(a) (1979).
[32] 24 C.F.R. §880.104(b), §881.104(b) (1979).
[33] 24 C.F.R. §880.109, §881.109 (1979).
[34] 24 C.F.R. §880.107(a), §881.107(a) (1979).
[35] 24 C.F.R. §880.107(b), (c); §881.107(b), (c) (1979).
[36] 24 C.F.R. §880.107(d), §881.107(d) (1979).
[37] 24 C.F.R. §880.115(b), §881.115(b) (1979).

- Management functions such as taking applications, selecting families, verifying family income and other requirements, and determining eligibility and amount of family contribution.
- Collection of rents.
- Termination of tenancies, including evictions.
- Preparation of required information.
- Reexamination of family income, composition, and expenses.
- Redetermination of the amount of the family contribution and housing assistance payments.
- Compliance with equal opportunity requirements.[38]

Eligibility

In all section 8 programs, families eligible to receive housing assistance must have an income that does not exceed 80 percent of the median income in the area; this ceiling may be adjusted because of local conditions, subject to HUD approval.[39] A "family" includes, in addition to individuals living together:

- Individuals over age 62;
- Disabled or handicapped individuals whether living alone, together, or with a person essential to their care;
- "Single persons" living alone;
- The remaining members of a tenant family; or
- A person displaced by government action or disaster (hereafter referred to as displaced).[40]

For the purposes of these programs, a "handicapped person" is one who has a physical or mental impairment of indefinite duration that substantially impedes his or her ability to live independently and that could be improved by more suitable housing conditions.[41]

Although single persons are eligible for section 8 assistance, because of statutory restrictions and limitations on certificate availability it is difficult for a single person who is not elderly, handicapped, or displaced to participate in the section 8 programs.[42] The statutory limitation that follows refers to all assisted housing:

> The term "families" includes families consisting of a single person in the case of (A) a person who is at least sixty-two years of age or is under a disability. . .or is handicapped, (B) a displaced person, (C) the remaining member of a tenant family and (D) other single persons. . .: *Provided,* that in no event shall more than 10 percent of the units under the jurisdiction of any public housing agency be occupied by single persons under this clause (D): *Provided further,* that in determining priority for admission. . .[HUD] shall give preference to those single persons who are elderly, handicapped, or displaced before those under this clause (D). . . .[43]

A family is eligible for section 8 assistance if it qualifies as a "lower income family," i.e., one whose income does not exceed 80 percent of the median for the area.[44] By statute, 30 percent of the units of initial occupancy must be set aside for "very low income families" (income does not exceed 50 percent of the median for the area).[45]

With certain specific exceptions, "all payments from all sources received by the family head (even if temporarily absent) and each additional member of the family household who is not a minor shall be included in the annual income of a family."[46] Although income is computed before payroll deductions, the following allowances are permitted: $300 for each child under 18, medical expenses in excess of 3 percent of annual income, and expenses for care of children under 13 or disabled and handicapped family members.[47] In computing income, the first $5,000 of a family's capital assets are excluded. Either the income from all other assets, or 10 percent of their value, is included in computing income.[48]

In selecting applicants to receive certificates, the PHA may establish "preferences" for different categories of families,[49] which are assigned priorities. If there is a waiting list of families who have applied for certificates, families in the preferred categories receive priority in selection when certificates are issued.

In the case of the new construction and substantial rehabilitation programs, the following groups are eligible to serve as owners of assisted projects. An owner is defined as: "Any private person or entity,

[38] 24 C.F.R. §880.119, §881.119 (1979).
[39] 42 U.S.C. §1437(f)(1)(1976).
[40] 24 C.F.R. §812.2(c), (d), (f) (1979).
[41] 24 C.F.R. §812.2(e) (1979).
[42] 24 C.F.R. §812.3 (1979).
[43] 42 U.S.C. §1437a(2)(1976).
[44] 24 C.F.R. §889.102 (1979).
[45] *Id.* (1979).
[46] 24 C.F.R. §889.104 (1979).
[47] 24 C.F.R. §889.102 (1979). Expenses incurred for care of young children or handicapped or disabled family members can be deducted from the annual income computation only when necessary to enable another family member to be employed, and then only to the extent of the income from that employment. *Id.*
[48] 24 C.F.R. §889.103(1979).
[49] 24 C.F.R. §882.209(a)(3); §882.204(b)(1)(i)(c).

including a cooperative, or a PHA having the legal right to lease or sublease newly constructed (or Substantially Rehabilitated) dwelling units."[50]

HUD's evaluation of section 8, published in 1978, indicates that, "Recipients were generally representative of the eligible population except that a disproportionately large share of elderly women and non-elderly female-headed households with children participated."[51] Most of the new construction funds have been used to support projects for the elderly, while existing housing funds have been utilized primarily by very low income, female-headed households.[52] In many jurisdictions there is a very lengthy (up to 3 years) waiting list for section 8 certificates under the existing housing program.[53]

Funding

The HUD area office reviews the local housing assistance plans and other documentation to "determine the number and types of units to be made available for new construction, substantial rehabilitation, moderate rehabilitation, and existing housing."[54]

Based on this determination the area office prepares and distributes either an invitation for a section 8 existing housing application or public housing applications. In the case of new construction and substantial rehabilitation, field offices prepare section 8 notification of fund availability for funds not set aside for State housing finance agencies. In response to these solicitations, PHAs submit applications for section 8 existing housing and moderate rehabilitation grants and owners/developers submit preliminary proposals for new construction and substantial rehabilitation projects.[55] The HUD area office reviews the responses and either approves or disapproves the project. For approved projects HUD signs an annual contributions contract with the PHA, which is then responsible for managing the funds, and an agreement with the owner of new construction and substantial rehabilitation projects.[56]

The section 8 program is "the major HUD program for providing federally assisted rental housing." The budgeted expenditures ("contract authority") for fiscal year 1980 totaled almost $950 million, with long-term obligations ("budget authority") of almost $21 billion.[57]

[50] 24 C.F.R. §880.102, §881.102 (1979).
[51] U.S., Department of Housing and Urban Development, *Lower Income Housing Assistance Program (Section 8): Nationwide Evaluation of the Existing Housing Program* (November 1978), p. xvi.
[52] Finkleman Interview.
[53] Ibid.
[54] 24 C.F.R. §880.202(a), §881.202(a), §882.202 (1979).
[55] 24 C.F.R. §§880.203, 204, 205; §§881.203, 204, 205; §§882.203, 204 (1979).
[56] 24 C.F.R. §§880.206–214; §§881.206–214; §§882.205–206 (1979).
[57] *FY 80 Budget Justification*, part 1, p. C–8.

Community Development Block Grant Program

The Housing and Community Development Act of 1974 (Public Law 93–383) altered significantly the Federal involvement in a wide range of housing and community development activities. It included the following eight titles:[1]

- Community Development (Title I),
- Assisted Housing (Title II),
- Mortgage Credit Assistance (Title III),
- Comprehensive Planning (Title IV),
- Rural Housing (Title V),
- Mobile Home Construction and Safety Standards (Title VI),
- Consumer Home Mortgage Assistance (Title VII), and
- Miscellaneous (Title VIII).

Title I, community development, consolidated several previous categorical programs (i.e., programs restricted to a particular purpose) for community development into a single program. The categorical programs replaced by Title I included: urban renewal, model cities, water and sewer facilities, neighborhood facilities, public facility loans, and open space.[2] The primary purpose of Title I, community development, was "the development of viable urban communities, by providing decent housing and a suitable living environment and expanding economic opportunities, principally for persons of low and moderate income."[3]

Under the community development block grant (CDBG) program, eligible communities receive a sum of Federal community development assistance on an annual basis. Congress aproved a two-tier formula for distributing the CDBG funds in the 1977 amendments to the Housing and Community Development Act.[4] This formula was designed to provide additional funding to the older central cities, which some considered to have been slighted under the initial 1974 formula that was based on population size and extent of poverty and overcrowding. The formula added in 1977 was based on the population growth lag, age of housing, and extent of poverty. As a result of this modification, cities may choose whichever formula provides the higher level of funding.[5]

The CDBG program includes both the "entitlement grants" and "small cities program."[6] Other funding programs included as part of the CDBG are the Secretary's Fund, urban development action grants, and the categorical program settlement fund.[7]

Organizational Structure

At the Federal level the Department of Housing and Urban Development is responsible for monitoring the Housing and Community Development Act. Within HUD, the Office of Community Planning and Development is responsible for administering these funds.[8]

HUD operates through a regional office structure. The 10 regional offices do not have program responsibility, but have management responsibility for 40 area offices.[9] The local plans for both the entitlement grants and the small cities grants are reviewed and most decisions made at the area office. In the small cities grant program, applications can be both approved and denied by area office staff. For the entitlement grants, applications may be approved at the area office, but denial made only by the staff of the national office. The staff of the regional offices are not involved in the application review and approval process.[10]

Eligible units of local government submit applications to the appropriate HUD area office. The applications detail the programs to be funded, including those initiated through citizen action.

Benefits

Two broad types of benefits can be supported with CDBG funds. The first is the benefit supported directly through the program. The second type of

[1] Pub. L. No. 93–383, 88 Stat 633, as amended by Pub. L. No. 95–128, 91 Stat. 1111.
[2] 24 C.F.R. §570.1(b) (1979).
[3] Pub. L. No. 93–393, §101(c), 88 Stat. 633, now codified at 42 U.S.C. §5301(c)(1976).
[4] U.S., Department of Housing and Urban Development, *Fourth Annual Report: The Community Development Block Grant Program* (September 1979), p. 1 (hereafter cited as *Fourth Annual Report).*
[5] Ibid. Pub. L. No. 95–128, §106(b); 24 C.F.R. §570.102.
[6] 24 C.F.R. §§570.300–312; §§570.420–435 (1979).
[7] 24 C.F.R. §§570.400–409; §§570.450–462; §§570.480–487 (1979).
[8] Ann Wiedel, Small Cities Program, Office of Community Planning and Development, Department of Housing and Urban Development, interview in Washington, D.C., Nov. 28, 1979 (hereafter cited as Wiedel Interview).
[9] Ibid.
[10] Ibid.

benefit is the potential for coordinating these services with other HUD programs, as well as those from other Federal agencies.

Direct Benefits

According to the act, the following activities may be supported with CDBG funds under both the entitlement grant and small cities programs:[11]

- Acquisition and disposition of property that is blighted, needs rehabilitation, or can be used for a wide variety of public purposes.
- Construction of public works and facilities, such as water and sewer facilities, neighborhood facilities, senior centers, centers for the handicapped, pedestrian malls, and utilities or other public services.
- Code enforcement in deteriorating areas.
- Demolition and/or rehabilitation of buildings.
- Removal of architectural barriers to the handicapped.
- Renting vacant units being held for relocating families displaced by CDBG activities.
- Providing otherwise unavailable services for the employment, crime prevention, child care, health, drug abuse, education, welfare, or recreation needs of residents in areas affected by community development activities.
- Completing projects originally funded under Title I of the Housing Act of 1949.
- Relocating displaced individuals, families, businesses, organizations, and farms.
- Developing a comprehensive community development plan and a policy-planning-management capacity.
- Providing administrative costs related to the community development program.
- Supporting related activities of public and private nonprofit organizations.
- Grants to neighborhood-based nonprofit organizations and local development corporations for neighborhood revitalization activities.

The actual services and projects supported by these funds are largely up to the discretion of local housing and community development officials. The priority needs of the community that are addressed by CDBG funds must be determined as part of the application and planning process.[12] The comments in the *Fourth Annual Report: Community Development Block Grant Program* are instructive:

> Although cities have considerable latitude in deciding what activities they may pursue, which areas of their cities to upgrade or treat with CDBG funds, and who is to benefit from the program, local CDBG activities must give *maximum feasible priority* to one of three program areas. Local communities must certify in their CDBG applications that planned activities: (1) benefit low- and moderate-income families; or (2) aid in the preservation or elimination of slums and blight; or (3) meet other community development needs having a particular urgency.[13]

Coordination

The benefits of both these programs may be used to facilitate coordination with other Federal programs. For example, CDBG funds can be used as matching funds for grants from other Federal agencies provided the activity represents an eligible use of CDBG funds.[14] Another HUD program that is related to participation in the community development block grant program is *the urban development action grant program,* which is designed to assist severely distressed cities and urban counties in overcoming economic development problems;[15] and includes *the neighborhood strategy area (NSA) program,* which is designed to provide local governments with special procedures for concentrating public and private community development resources in particular neighborhoods.[16]

Eligibility

Community development block grant funds are distributed to units of local government, which may then award subgrants to public and private agencies. Two major types of grants are available with CDBG funds: the entitlement grants and the small cities programs. Of the funds appropriated for this program in each fiscal year, certain amounts are specified in the act for particular purposes.[17] Of the remaining money, 80 percent is allocated to metropolitan areas and 20 percent to nonmetropolitan areas.[18]

Entitlement Grants

The 80 percent of CDBG funds allocated to the entitlement grants program are distributed to "metropolitan cities" or "urban counties." A metropoli-

[11] 42 U.S.C. §5305(a)(1976); 24 C.F.R. §§570.201–207(1979).
[12] 24 C.F.R. §570.301(a).
[13] *Fourth Annual Report,* pp. 11–4, 6.
[14] 42 U.S.C. §5305(a)(9)(1976); 24 C.F.R. §570.201(g)(1979).
[15] 42 U.S.C. §5318 (1976).
[16] 24 C.F.R. §570.301(c); 881.301–309 (1979).
[17] 42 U.S.C. §5303 (1976).
[18] 42 U.S.C. §5306(a)(1976); 24 C.F.R. §570.101 (1979).

tan city is one that has a population of 50,000 or more, or is a central city within a standard metropolitan statistical area (SMSA).[19] Urban counties include any county within a SMSA that is authorized under State law to undertake essential community development and housing assistance activities in unincorporated areas, and either: (1) has a combined population of 200,000 or more outside the metropolitan cities and Indian tribes; or (2) has a population in excess of 100,000, a population density of at least 5,000 per square mile, and contains within its boundaries no incorporated places as defined by the census.[20]

To receive an entitlement grant, a community must submit to HUD: (1) a community development and housing plan every 3 years, updated annually with (2) a community development program and (3) an annual housing action program.[21] The community development and housing plan must summarize the community development and housing needs, set forth a comprehensive plan for meeting those needs, and identify specific projects and activities planned over the 3-year period covered by the plan.[22] In addition, it must include a housing assistance plan describing the housing conditions and the housing needs of low- and moderate-income persons and establish goals to meet those needs.[23] In addition to the funding application submitted with the 3-year community development plan, entitlement communities must submit annual requests for funds to HUD.[24]

Small Cities

The remaining 20 percent of the funds appropriated to the community development block grant program is distributed competitively through the small cities program.[25] States and local government units, including counties (exclusive of metropolitan or central cities of an SMSA), urban counties, and Indian tribes, are eligible to apply.[26] Generally speaking, cities of less than 50,000 population are eligible.[27]

[19] 42 U.S.C. §5302(a)(4)(1976); 24 C.F.R. §570.3(r)(1979).
[20] 42 U.S.C. §5302(a)(6)(1976 and Supp. 1977); 24 C.F.R. §570.3(w)(1979).
[21] 24 C.F.R. §570.301, 304, 305, 306 (1979).
[22] 24 C.F.R. §570.304 (1979).
[23] 24 C.F.R. §570.300 (1979).
[24] *Id.*
[25] 24 C.F.R. §570.420 (1979).
[26] 24 C.F.R. §570.420(c)(1979).
[27] Wiedel Interview.

In response to the widely varying needs of eligible communities, both comprehensive and single-purpose grants may be awarded.[28] Applicants may apply for only one type of grant, not both.[29] A comprehensive program must:[30]

- Address a substantial portion of the identifiable community developments needs in a defined, concentrated area;
- Involve two or more related activities carried out in a coordinated manner;
- Have beneficial impact within a reasonable period of time; and
- Be developed through assessment of the community's development, housing, and economic needs.

A single-purpose program will provide funds for one or more projects consisting of activities designed to meet a specific community development need.[31]

The first step in competing for small cities funds is to submit a preapplication to the HUD area office, in accordance with the "review process statement" distributed in advance of the competition.[32] While the central HUD office now has distributed a national "review process statement" for area offices to use as a model, each of the 40 individual offices is responsible for preparing its own review process statement that describes the content of the grant applications.[33] During the review process, the best preapplication is identified by rating according to criteria in the regulations.[34]

Both single-time funding and multiyear funding options are available in the small cities comprehensive program. The multiyear applications cannot exceed 3 years.[35] Most of the multiyear applications cover the full 3-year period, although a few awards have been made on a 2-year basis. The single-time funding is usually used for single-purpose grants.[36]

Funding

The entitlement community receives a proportion of the total funds allocated to all metropolitan areas computed by whichever of the following formulas provides the larger grant:

[28] 24 C.F.R. §570.420(d) (1979).
[29] 24 C.F.R. §570.420(g) (1979).
[30] 24 C.F.R. §570.423(a) (1979).
[31] 24 C.F.R. §570.427(a) (1979).
[32] 24 C.F.R. §570.425, 429 (1979); Wiedel Interview.
[33] Wiedel Interview.
[34] 24 C.F.R. §570.424, 428 (1979).
[35] 24 C.F.R. §570.423(b) (1979); Weidel Interview.
[36] Wiedel Interview.

(1) The average of the ratios between:

- The population of the entitlement community and the population of all metropolitan areas (weighted once);
- The extent of poverty in the entitlement community and the extent of poverty in all metropolitan areas (weighted twice); and
- The extent of housing overcrowding in the entitlement community and the extent of housing overcrowding in all metropolitan areas (weighted once); or

(2) The average of the ratios between:

- The extent of growth lag in the entitlement community and the extent of growth lag in all metropolitan areas (weighted once);
- The extent of poverty in the entitlement community and the extent of poverty in all metropolitan areas (weighted one and one-half times); and
- The age of housing in the entitlement community and the age of housing in all metropolitan areas (weighted two and one-half times).[37]

Funding levels for the entire CDBG program have generally increased, from an initial appropriation of $2.4 billion in fiscal year 1975 to $3.8 billion in fiscal year 1980.[38] Of the total fiscal year 1980 appropriation, $856.5 million was set aside for specific purposes.[39] The remainder is available for the entitlement grants and small cities programs. An additional $100 million was authorized for each of the fiscal years 1978, 1979, and 1980 for grants to localities requiring supplemental assistance to complete prior categorical projects, such as urban renewal.[40]

[37] 24 C.F.R. §570.102 (1979).
[38] *Fourth Annual Report*, p. 12; and U.S., Department of Housing and Urban Development, *Justification for 1980 Estimates* (March 1979) (hereafter referred to as *FY 80 Budget Justification).*

[39] 24 C.F.R. §570.101 (1979).
[40] *FY 80 Budget Justification*, part 2, p. A-12.

Legal Services Corporation

The Legal Services Corporation Act passed by Congress in 1974 and amended in 1977 created a private, nonprofit corporation to provide legal assistance in civil matters to low-income people.[1] (In criminal matters, public defenders and court-appointed private lawyers may be available to assist persons unable to afford private counsel.[2])

Until the creation of the Corporation, legal assistance to the poor was provided through the poverty law program of the Office of Economic Opportunity (OEO).[3] The Legal Services Corporation Act, which amended the Economic Opportunities Act of 1964,[4] provided for the transfer of legal assistance from the Executive branch in order to "insulate legal assistance for the poor from partisan political pressures."[5]

Organizational Structure

The Legal Services Corporation (LSC) is governed by an 11-member Board of Directors appointed by the President with the advice and consent of the Senate. No more than six members of the Board can be of the same political party, and at least two members of the Board must be eligible clients.[6] The Board appoints its president who must be a member of the bar of the highest court of a State.[7]

The act authorizes the Corporation to provide financial assistance to "qualified programs furnishing legal assistance to eligible clients" and to "make grants and contracts" with local legal service providers for this purpose.[8] At the present time, the Corporation distributes grants to 335 legal assistance programs through its Office of Field Services and 9 regional offices. These programs operate throughout the country in over 1,100 neighborhood offices staffed by 6,100 lawyers and 2,800 paralegals.[9]

The act states that local programs will be governed by a Board of Directors, at least 60 percent of whom are private attorneys and one-third eligible clients who may also be "representative" of groups of eligible clients.[10] Regulations issued under the act mandate that the eligible clients on the Board *must* represent their communities.[11] Local boards are responsible for hiring attorneys and other staff to run individual sites.[12]

Benefits

Through local legal services programs, legal assistance in civil matters is available to eligible clients. In some instances, the act places restrictions on the nature of the assistance provided and the kinds of activities undertaken by legal services programs.[13] The act stipulates that legal assistance cannot be provided in fee-generating cases, except in specific instances as stipulated in the regulations.[14] Also excluded are matters involving some types of abortion cases,[15] violations of the Selective Service Act, armed services desertion cases,[16] and matters involving school desegregation.[17] Additionally, legal services funds cannot be used to support political activities, public demonstrations, picketing, or strikes.[18] The act also limits legislative advocacy activities by local program employees.[19] The regulations state that Corporation funds cannot be used to influence legislative activity on local, State, or Federal levels except: (1) when requested by a governmental agency or legislative body, committee, or member; (2) on behalf of an eligible client who may be affected by the outcome of a particular piece of legislation or administrative measure; or (3) when a particular government agency or legislative

[1] 42 U.S.C. §§2996–2996(1)(1976 & Supp. 1977).
[2] Jeanne Connelly, Office of Government Relations, Legal Services Corporation, interview in Washington, D.C. Oct. 16, 1979 (hereafter cited as Connelly Interview, Oct. 16, 1979).
[3] Legal Services Corporation (LSC), "News Background Release," prepared by the Public Affairs Department, September 1979, p. 1. (hereafter cited as LSC, "News Background Release").
[4] *42 U.S.C. §2701–2996 (1)(1976 & Supp 1977).*
[5] *LSC, "News Background Release," p. 1.*
[6] *42 U.S.C. §2996c (a)(Supp. 1977).*
[7] *42 U.S.C. §2996d(a)(1976).*
[8] *Id.* at §2996e(a)(1)(A).
[9] LSC, "News Background Release," p. 1.
[10] *Id.* at §2996f(c).
[11] 42 C.F.R. §1607.3(e)(1979).
[12] LSC, "News Background Release," p. 3.
[13] Connelly Interview, Oct. 16, 1979.
[14] 42 U.S.C. §2996f(b)(1)(Supp. 1977). Elaboration of cases in which fee-generating cases may be accepted can be found at 45 C.F.R. §§1609.3, .4(1979).
[15] *Id.* at §2996f(b)(8).
[16] *Id.* at §2996f(b)(10).
[17] *Id.* at §2996f(b)(9).
[18] *Id.* at §§2996f(a)(6)(b)(6).
[19] 42 U.S.C. §§2996e(c)(2), 2996f(a)(5)(1976 & Supp. 1977).

body is considering a measure that directly affects the activities of the Corporation or its recipients.[20]

The act also limits involvement of local programs in class action suits, which cannot be undertaken except with the approval of a project director.[21] The regulations state that local governing bodies should establish policy for assisting project directors in making a determination about the approval of class action suits.[22]

Local programs determine the types of cases that they can successfully handle,[23] and the types of legal matters that they address vary throughout the country.[24] The act instructs local programs to devise procedures for "determining and implementing priorities," taking into account the "relative needs of eligible clients," including the elderly and handicapped, and to provide appropriate training and support.[25] Guidelines for establishing a procedure and review process in priority settings are provided in the regulations.[26] The regulations also stipulate that local programs must assess eligible clients' needs.[27] The views and active participation of all significant segments of the client community, as well as local program employees, should be included in the needs assessment and subsequent priority setting.[28] Factors such as the resources of the local programs, the availability of other resources in the community, the relative importance of different categories of need, the general effect of resolving problems in particular categories of need, and the susceptibility of particular problems to solutions should be considered.[29]

Of the 1.4 million cases brought to LSC attorneys in 1978, 35 percent dealt with family law problems, 15 percent with consumer law, 15 percent with housing issues, 15 percent with administrative benefits, and the remaining 20 percent with a variety of other legal issues.[30]

[20] 45 C.F.R. §1612.4 (1979).
[21] 42 U.S.C. §2996e(d)(5) (1976).
[22] 45 C.F.R. §1617.4 (1979).
[23] 42 U.S.C. §2996f(a)(2)(C)(Supp. 1977).
[24] Jeanne Connelly, Legal Services Corporation, interview in Washington, D.C. on Oct. 17, 1979 (hereafter cited as Connelly Interview, Oct. 17, 1979).
[25] 42 U.S.C. §2996f(a)(2)(C) (Supp. 1977).
[26] 45 C.F.R. §1620 (1979).
[27] Id. at §1620.2(a)(1).
[28] Id. at §1620.2(a)(1)&(2).
[29] Id. at §1620.2(b)(3), (4),(6),(7), and (8).
[30] LSC, "News Background Release," p. 2.
[31] 42 U.S.C. §2996e(a)(3)(A),(B),(C), (1976 & Supp. 1977).

The Corporation is also authorized by the act to undertake research, training, and technical assistance, and to "serve as a clearinghouse for information."[31] Fifteen national backup centers provide research and litigation assistance to local attorneys and programs on complex legal problems.[32] Staff of the centers provide written materials to local programs, testify before Federal and State legislative and administrative bodies, and handle test litigation.[33] Some centers focus on substantive areas such as housing, consumer rights, administrative benefits, and health plans. Others focus on the legal problems of specific groups, such as Native Americans, the elderly, and migrant farmworkers.[34] One of the newest centers is the Women and Family Law Center, which focused on the legal problems of domestic violence victims during its first year.[35]

Some States have State support centers that perform functions similar to the national support centers, but they are not limited to one substantive issue or client group. Specifically, they may be involved in statewide training and legislative advocacy on a variety of legal issues..[36]

The Research Institute on Legal Assistance, established in 1976 to study legal problems encountered by the poor that relate to the legal services programs, deals with both "substantive and procedural"[37] legal problems. Research is done in areas such as health benefit programs, gaps in poverty law, and hearing and grievance procedures of agencies providing benefits to the poor.[38] Small research grants are available from the Research Institute, and a project on the civil remedies available to domestic violence victims was recently completed.[39]

The Corporation also awards grants for experimental projects designed to improve legal services for the poor. Grants are awarded to "low income community organizations, client councils, bar associations, private law firms and legal services programs

[32] Connelly Interview, Oct. 16, 1979.
[33] Legal Services Corporation, *1978 Annual Report*, p. 8 (hereafter cited as *1978 Annual Report).*
[34] LSC, "News Background Release," p. 4.
[35] Laurie Woods, director, National Center on Women and Family Law, telephone interview, Oct. 29, 1979 (hereafter cited as Woods Interview).
[36] Jeanne Connelly, Office of Government Relations, Legal Services Corporation, telephone interview, Oct. 25, 1979 (hereafter cited as Connelly Interview, Oct. 25, 1979).
[37] *1978 Annual Report*, p. 12.
[38] LSC, "News Background Release," p. 6.
[39] Connelly Interview, Oct. 25, 1979.

to carry out activities that have the potential to yield information critically needed throughout the legal services community."[40] Grants have been awarded in various categories, including rural service delivery, delivery of services to the handicapped, client involvement, and preventive law.[41] The availability of these discretionary funds is very limited. The remaining money will be used to fund programs designed to improve legal service delivery in rural areas.[42]

Eligibility

The act establishes a maximum income level for the receipt of legal services; stipulates that variations in family size, urban and rural differences, and substantial cost of living variations be considered; and provides some factors for consideration in making an eligibility determination.[43] The regulations stipulate that the maximum income level for the receipt of services is 125 percent of the Office of Management and Budget poverty level, but give local programs the prerogative to set their own maximum income level within that framework.[44] Before local programs set a maximum income level, they must consider such factors as the cost of living in the area, the number of clients the local program can reasonably serve, the population eligible at a lower income level cutoff, and the availability and cost of other legal services.[45] The amount of funding the local office might have from other sources is also a consideration.[46] The regulations allow local programs to consider factors that might affect a potential client's ability to pay for legal services such as fixed debts and obligations, liquid net assets, child care expenses, seasonal income variables,[47] and the consequences for the individual if legal assistance is denied.[48]

Funding

Through funds appropriated by Congress, the Legal Services Corporation distributes formula grants to local programs. Funding for fiscal year 1979 was $270 million and for fiscal year 1980, $300 million.[49] Funding for individual programs is determined by a formula that takes into account the number of individuals in a particular area whose income is at 125 percent of the poverty threshold established by OMB and makes an allowance of approximately $7 for each person in that income bracket. The bulk of LSC's funding goes toward maintaining existing programs and finishing expansion efforts to cover areas without services in 1975 when the Corporation first came into existence.[50]

[40] *1978 Annual Report*, p. 11.
[41] Ibid.
[42] Connelly Interview, Oct. 25, 1979.
[43] 42 U.S.C. §2996f(a)(2)(A),(B)(1976 & Supp. 1977).
[44] 45 C.F.R. §1611.3 (1979).
[45] 45 C.F.R. §1611.3(c)(1979).
[46] Connelly Interview, Oct. 17, 1979.
[47] 45 C.F.R. §1611.5(b)(1)–(4)(1979).
[48] *Id.* at §1611.5(b)(7).
[49] Connelly Interview, Oct. 16, 1979.
[50] Jeanne Connelly, Legal Services Corporation, telephone interview, Nov. 19, 1979.

Law Enforcement Assistance Administration, National Priority Grants Program and Discretionary Grants Program

The discretionary grants program of the Law Enforcement Assistance Administration (LEAA), Department of Justice, was originally established by parts C and E of Title I of the Omnibus Crime Control and Safe Streets Act of 1968.[1] The Justice System Improvement Act of 1979, enacted December 27, 1979, makes major changes to the LEAA program.[2] These changes include establishment of the national priority grants program and the discretionary grants program, which together will replace the discretionary grant program established under parts C and E of the Omnibus Crime Control Act.[3]

The national priority grants program is established in part E of the new act to encourage States and local governments to carry out programs "which through research, demonstration, or evaluation have been shown to be effective or innovative, and to have a likely beneficial impact on criminal justice."[4] Specific priority programs for replication are to be identified annually, and each program may remain a priority for up to 3 years.

The discretionary grants program is established under part F of the new act. The purpose of this program is to encourage States, units or combinations of units of local government, or private nonprofit organizations to develop innovative approaches to criminal justice problems.[5]

Organizational Structure

The act establishes within the Department of Justice, the Office of Justice Assistance, Research, and Statistics (OJARS),[6] and, under the coordination of OJARS,[7] the Law Enforcement Assistance Administration (LEAA).[8] Under the act, LEAA is authorized to award formula grants (§§401–405), national priority grants (§§501–505), and discretionary grants (§§601–606) to eligible applicants, as well as to cooperate with and provide technical assistance to State and local governments and public and private organizations.[9] Determination of the types of programs and projects to be linked under both the national priority and discretionary grants programs will be made by the Director of OJARS and the Administrator of LEAA jointly.[10]

The priorities, programs, and specific application and eligibility requirements for both programs must be published in the Federal Register for public comment.[11]

Benefits

Projects under both programs may be funded for up to 3 years.[12] If budget constraints prevent recipients of National Priority or Discretionary grants from assuming the costs, the project may be funded for an additional 2 years, if an evaluation shows that it has been effective.[13]

The national priority program is generally intended to identify and replicate programs and practices which have been shown to be effective or innovative and are likely to have a beneficial impact on criminal justice.[14] These may include improvements in the comprehensive planning and coordination of State and local criminal justice activities.[15] Grants may equal 50 percent of the cost of the priority program or, under special circumstances as specified in the legislation, may equal 100 percent of the cost.[16]

[1] 42 U.S.C. §§3731–39, §§3741–47, §§3750–3750d.

[2] John Lawton, Congressional Liaison Officer of the Law Enforcement Assistance Administration, interview in Washington, D.C., Dec. 7, 1979 (hereafter cited as Lawton Interview); also Jeannie Niedermeyer Santos, family violence program manager, and Ken Carpenter, Director, Special Programs Division, Law Enforcement Assistance Administration, Interview in Washington, D.C., Dec. 11, 1979 (hereafter cited as Santos Interview).

[3] Pub. L. No. 96–157, 93 Stat. 1167, §§501–606 (1979); Santos Interview.

[4] Pub. L. No. 96–157, 93 Stat. 1167, §§501, 503(a) (1979).

[5] *Id.* at §601.

[6] *Id.* at §801(a).

[7] *Id.* at §801(b).

[8] *Id.* at §101.

[9] *Id.* at §§102(2)–(7), §§103(a)(1), 505(b).

[10] *Id.* at §§503, 603.

[11] Pub. L. No. 96–157, 93 Stat. 1167, §§503(b), 505(a), 603(b) (1979).

[12] *Id.* at §§503(a), 603(a).

[13] *Id.* at §§505(d), 606.

[14] *Id.* at §503(a).

[15] *Id.*

[16] *Id.* at §505(b).

LEAA may provide technical assistance to any national priority program or project.[17]

Discretionary grants may equal 100 percent of the cost of the program funded.[18] Grant funds are to be used to:

(1) undertake programs and projects, including educational programs, to improve and strengthen the criminal justice system;

(2) improve the comprehensive planning and coordination of State and local criminal justice activities, especially coordination between city and county jurisdictions;

(3) provide for the equitable distribution of funds under Title I among all segments and components of the criminal justice system;

(4) develop and implement programs and projects to redirect resources so as to improve and expand the capacity of States and units of local government and combinations of such units, to detect, investigate, prosecute, and otherwise combat and prevent white-collar crime and public corruption. . .to enhance the overall criminal justice system response to white-collar crime and public corruption, and to foster the creation and implementation of a comprehensive national strategy to prevent and combat white-collar crime and public corruption;

(5) support modernization and improvement of State and local court and corrections systems and programs;

(6) support organized crime programs, programs to prevent and reduce crime in public or private places and programs which are designed to disrupt illicit commerce in stolen goods and property; and

(7) support community and neighborhood anticrime efforts.[19]

Discretionary funds are also to be used for awards to private nonprofit organizations for developing and conducting programs and projects which would not be otherwise undertaken.[20] These may include projects:

(1) to stimulate and encourage the improvement of justice and the modernization of State court operations by means of financial assistance to national nonprofit organizations operating in conjunction with and serving the judicial branches of State governments;

(2) to provide national education and training programs for State and local prosecutors, defense personnel, judges and judicial personnel, and to disseminate and demonstrate new legal developments and methods by means of teaching, special projects, practice, and the publication of manuals and materials to improve the administration of criminal justice. Organizations supported under this paragraph shall assist State and local agencies in the education and training of personnel on a State and regional basis;

(3) to support community and neighborhood anticrime programs;

(4) to stimulate, improve, and support victim-witness assistance programs; and

(5) to improve the administration of justice by encouraging and supporting the development, dissemination, implementation, evaluation, and revision of criminal justice standards and guidelines.[21]

Until the specific projects to be funded under the national priority grants and discretionary grants programs are determined, it is not possible to specify what the exact benefits to individuals from the programs will be.

Eligibility

For both of these programs, States and units of local government and their criminal justice agencies are eligible applicants.[22] Private nonprofit agencies are also eligible for discretionary grants, and eligible for national priority grants as a subgrantee of an eligible State or local unit of government.[23]

In order to receive a grant under either program the potential grantee must submit an application to LEAA, responding to the program guidelines.[24]

Applications for national priority grants must identify the specific priority program for which funds are requested, and must describe in detail the relationship between the State's formula grant and national priority grant expenditures.[25] In determining projects to be supported, LEAA will:

Give consideration to the criminal justice needs and efforts of eligible jurisdictions, to the need for continuing pro-

[17] *Id.*
[18] *Id.* at §605.
[19] *Id.* at §601.
[20] *Id.* at §602.
[21] *Id.*
[22] *Id.* at §§501 and 601.
[23] *Id.* at §§504(d), 601, 602.
[24] *Id.* at §§504(a) and 604(a).
[25] *Id.* at §504(a).

grams which would not otherwise be continued because of the lack of adequate part D funds, and to the degree to which an eligible jurisdiction has expended or proposed to expend funds from part D or other sources. . .for priority programs.[26]

Applications for discretionary grants must describe the project goals and methods, evaluation procedures, the grantee organization and its relationship to the affected units of State and local governments.[27]

[26] *Id.* at §505(a).
[27] *Id.* at §604(a).
[28] Phyllis Black, budget analyst, Office of the Comptroller, Law Enforcement Assistance Administration, telephone interview in Washington, D.C., Dec. 12, 1979 (hereafter cited as Black interview).
[29] Ibid.
[30] Ibid.

Funding

As part of the overall LEAA budget reduction for fiscal year 1980, funds for the national priority and discretionary grant programs were also reduced.[28] For fiscal year 1980, the national priority program had a budget of $29,904,000 and the discretionary grant program was budgeted at $29,905,000,[29] for a combined total of $59,809,000. For fiscal year 1979, the part C and E discretionary budget (the comparable figure) was $78,070,000.[30]

Law Enforcement Assistance Administration, Formula Grant Program

Overview

The Law Enforcement Assistance Administration (LEAA) in the Department of Justice was established by Title I of the Omnibus Crime Control and Safe Streets Act of 1968.[1] This legislation has been amended significantly by five subsequent acts.[2] The Justice System Improvement Act of 1979 (hereafter referred to as the act), enacted December 27, 1979, makes major changes in the LEAA funding, structure, and programs. The major changes and, in particular, the formula grant program established by the act are reviewed in this report.

The formula grant program is established in part D of the act (§§401–405). The purpose of the program, as stated in the act, is as follows:

> . . .to assist States and units of local government in carrying out specific innovative programs which are of proven effectiveness, have a record of proven success, or which offer a high probability of improving the functioning of the criminal justice system. The Administration is authorized to make grants under this part to States and units of local government. . .[3]

Organizational Structure

The act establishes the Office of Justice Assistance, Research, and Statistics (OJARS) under the general authority of the Attorney General and administered by a director appointed by the President with the advice and consent of the Senate.[4] The role of OJARS is to provide staff support to, and coordinate the activities of, its three major organizational components.[5] These components, each of which is administered by a Presidential appointee approved by the Senate, include the Law Enforcement Assistance Administration (LEAA),[6] the National Institute of Justice (NIJ),[7] and the Bureau of Justice Statistics (BJS).[8] Under the act, LEAA is authorized to award formula grants (part D, §§401–405), national priority grants (part E, §§501–505)), and discretionary grants (part F §§601–606) to eligible applicants, as well as to cooperate with and provide technical assistance to State and local governments and public and private organizations.[9]

The NIJ has responsibility to provide for research and demonstration efforts for:

- improving the criminal and civil justice systems;
- preventing and reducing crimes;
- insuring citizen access to dispute resolution;
- combatting white collar crime and public corruption; and
- identifying successful programs.[10]

The BJS is responsible for the collection and analysis of statistical information concerning crime and the operation of the criminal and civil justice systems, and for the development of information and statistical systems to support these activities.[11] The administrative head of each of the three OJARS components has "sign-off" authority over grants, contracts and cooperative agreements.[12]

In order to participate in the formula grant program a State must establish a criminal justice council (hereafter referred to as the council), local offices of the council, and a judicial coordinating committee.[13] These organizations are the functional equivalents of, respectively: the State planning agency, the regional planning units, and the judicial planning units, and the judicial planning committee established under the previous LEAA legislation.[14]

The council is responsible for:

> (A) analyzing the criminal justice problems within the State based on input and data from all eligible jurisdictions, State agencies, and the judicial coordinating committee and establishing priorities based on the analysis. . .;
>
> (B) preparing a comprehensive State application reflecting the statewide goals, objectives, priorities, and projected grant programs;
>
> (C)(i) receiving, reviewing, and approving (or disapproving) applications or amendments submitted by State

[1] 42 U.S.C. §§3701–3796c (1976 and Supp. 1977).
[2] *Id.*
[3] Pub. L. No. 96–157, §401(a), 93 Stat. 1167 (1979).
[4] *Id.* at §801(a).
[5] *Id.* at §801(b).
[6] *Id.* at §101.
[7] *Id.* at §201.
[8] *Id.* at §301.
[9] *Id.* at §102.
[10] Pub. L. No. 96–157 §201, 93 Stat. 1167 (1979).
[11] *Id.* at §301.
[12] *Id.* at §1301(b), (c), (d).
[13] *Id.* at §§401(c)(1), 402(b)(2), 402(c), 402(d).
[14] 42 U.S.C. §3723 (1976 & Supp. 1977).

agencies, the judicial coordinating committee, and units of local government, or combinations thereof. . .;

(C)(ii) providing financial assistance to these agencies and units. . .;

(D) receiving, coordinating, reviewing, and monitoring all applications or amendments. . ., recommending ways to improve the effectiveness of the programs or projects. . ., and integrating said applications into the comprehensive State application;

(E) preparing an annual report for the [Governor] and the State legislature containing an assessment of the criminal justice problems and priorities within the State. . .;

(F) assisting the [Governor], the State legislature, and units of local government upon request in developing new or improved approaches, policies, or legislation designed to improve criminal justice in the State;

(G) developing and publishing information concerning criminal justice in the State;

(H) providing technical assistance upon request to State agencies, community-based crime prevention programs, the judicial coordinating committee, and units of local government in matters relating to improving criminal justice in the State; and

(I) assuring fund accounting, auditing, and evaluation of programs and projects funded. . . .[15]

The council must be created or designated by State law and under the jurisdiction of the Governor, who appoints the council members.[16] The council membership must include representatives of:

- the units of local government with at least 100,000 population that account for 0.15 percent of the total criminal justice expenditures;
- smaller units of government;
- police, courts, corrections, prosecution, defense, and juvenile agencies;
- general public, including neighborhood and community-based and business and professional organizations; and
- the judiciary, including the chief judicial officer of the court of last resort, the chief judicial administrative officer of the State, and a local trial court judicial officer, unless they choose not to serve, in which case specific selection procedures are described.[17]

Individual council members may fulfill more than one of these requirements, where appropriate.[18]

Units of local government and public and private agencies at the State and local level receive subgrants from the council. Some units of local government are eligible to receive a subgrant, commonly known as a "mini-block grant,"[19] for all projects in their geographic area. Such grants are comparable in scope to the formula grant the council receives from LEAA.

Benefits

The act authorizes LEAA to award grants to State and local governments for programs which serve the following purposes:

(1) establishing community and neighborhood programs to deal with crime and delinquency;

(2) improving and strengthening law enforcement agencies. . .;

(3) improving the police utilization of community resources through support of joint police-community projects designed to prevent or control neighborhood crime;

(4) disrupting illicit commerce in stolen goods and property and training of special investigative and prosecuting personnel, and the development of systems for collecting, storing, and disseminating information relating to the control of organized crime;

(5) combating arson;

(6) developing investigations and prosecutions of white collar crime, organized crime, public corruption related offenses, and fraud against the government;

(7) reducing the time between arrest or indictment and disposition of trial;

(8) implementing court reforms;

(9) increasing the use and development of alternatives to the prosecution of selected offenders;

(10) increasing the development and use of alternatives to pretrial detention that assure return to court and a minimization of the risk of danger;

[15] Pub. L. No. 96-157 §402(b)(1), 93 Stat. 1167 (1979).
[16] *Id.* §402(b)(2).
[17] *Id.*
[18] *Id.*
[19] John Lawton, Congressional Liaison Officer of the Law Enforcement Assistance Administration, interview in Washington, D.C., Dec. 7, 1979 (hereafter cited as Lawton Interview); also Jeannie Niedermeyer Santos, family violence program manager, and Ken Carpenter, Director, Special Programs Division, Law Enforcement Assistance Administration, interview in Washington, D.C., Dec. 11, 1979 (hereafter cited as Santos Interview).

(11) increasing the rate at which prosecutors obtain convictions against habitual, nonstatus offenders;

(12) developing and implementing programs which provide assistance to victims, witnesses, and jurors, including restitution by the offender, programs encouraging victim and witness participation in the criminal justice system, and programs designed to prevent retribution against or intimidation of witnesses by persons charged with or convicted of crimes;

(13) providing competent defense counsel for indigent and eligible low-income persons accused of criminal offenses;

(14) developing projects to identify and meet the needs of drug-dependent offenders;

(15) increasing the availability and use of alternatives to maximum-security confinement of convicted offenders who pose no threat to public safety;

(16) reducing the rates of violence among inmates in places of detention and confinement;

(17) improving conditions of detention and confinement in adult and juvenile correctional institutions. . .;

(18) training criminal justice personnel in programs meeting standards. . .;

(19) revision and recodification. . .of criminal statutes, rules, and procedures and revision of statutes, rules, and regulations governing State and local criminal justice agencies;

(20) coordinating the various components of the criminal justice system to improve the overall operation of the system, establishing criminal justice information systems, and supporting and training of criminal justice personnel;

(21) developing statistical and evaluative systems. . .;

(22) encouraging the development of pilot and demonstration projects for prison industry programs at the State level with particular emphasis on involving private sector enterprise. . .; and

(23) any other innovative program which is of proven effectiveness, has a record of proven success, or which offers a high probability of improving the functioning of the criminal justice system.[20]

All grants for these purposes in fiscal year 1980 may be up to 100 percent of the program cost, but for later fiscal years may be for no more than 90 percent of the total project costs.[21] The 10 percent match must be in cash.[22] The match requirements may be eliminated in grants to Indian tribes or other aboriginal groups if they do not have sufficient funds.[23]

Formula grant (part D) funds may also be used for grants to the State criminal justice council for administering the projects supported under the formula grant program and operating the council, local offices, and judicial coordinating committee.[24] These administrative funds are the replacement for the part B planning grants in the Omnibus Crime Control Act.[25] Unexpended formula grant funds revert to LEAA for distribution among the States and local governments.[26]

Eligibility

In order to participate in the formula grant program, a State criminal justice council must submit a 3-year application, updated annually if programs are added or deleted.[27] This application must include comparable applications to the council from eligible jurisdictions, organizations, and agencies within the State.[28] The State application must include the following:

- An analysis of crime problems and criminal justice needs, a description of services to be provided, and specifically, how they will comply with the 23 program objectives discussed in the benefits section;
- An indication of how the programs relate to other programs; and
- Assurances regarding performance reporting; program evaluation; nonsupplanting of State or local funds; adequate support of courts, corrections, police, prosecution, and defense programs; accounting, auditing, monitoring and evaluation; data collection and report preparation; accuracy certifications; and equipment usage if purchased with grant funds.[29]

[20] Pub. L. No. 96-157 §401(a), 93 Stat. 1167 (1979).
[21] *Id.*
[22] *Id.* at §401(b)(1).
[23] *Id.* at §401(b)(2)(B).
[24] *Id.* §401(c)(1).
[25] 42 U.S.C. §§3721-26 (1976 & Supp. 1977).
[26] Pub. L. No. 96-157 §401(c)(2), 93 Stat. 1167 (1979).
[27] *Id.* at §403(a).
[28] *Id.* at §402(b)(3)(A).
[29] *Id.* at §403(a).

Judicial coordinating committees, State agencies and other nongovernmental grantees may utilize the council's crime analysis rather than preparing a separate one.[30]

Units of local government eligible to receive the "mini-block grants," described above under organizational structure, are municipalities and counties with populations of at least 100,000. A further requirement for eligibility is that the recipient unit of government must account for at least 0.15 percent of the total criminal justice expenditures in the State. Despite these eligibility criteria, a council must award "mini-block grants" only if they would amount to at least $50,000.[31] Combinations of contiguous units of local government totaling 100,000 population are also entitled to a "mini-block grant".[32] The council may, however, elect to award "mini-block grants" to units of local government which are not eligible according to these criteria.[33]

Funding

The LEAA budget was reduced significantly in fiscal year 1980. In fiscal year 1979 the total budget for the agency was $646,488,000, and the comparable figure for fiscal year 1980 is $486,463,000.[34] Of these funds, $100 million plus 19.14 percent of the remainder was set aside for juvenile justice purposes in both years.[35] In fiscal year 1980 the total appropriated for formula grants was $239,234,000, in contrast to the fiscal year 1979 combined appropriation of $346,668,000 for the planning grants, block grants, and correctional programs (parts B, C, and E) of the Omnibus Crime Control Act.[36]

The formula grant part D funds appropriated in fiscal year 1980 was distributed among the participating States. Each State received a minimum of $300,000 and a percentage of the remaining formula grant funds based on whichever of the following formulas provided the larger grant:

(1) The State's proportion, compared to all States, of:
   (a) population;
   (b) number of index crimes;
   (c) criminal justice expenditures; and
   (d) personal income.

(2) The State's proportion of the population, compared to all States. In no case may the grant under the first formula exceed 110 percent of the grant the second formula would permit.[37]

Of the funds awarded to each State, 70 percent is distributed among the eligible State and local jurisdictions discussed above. These allocations are based on the proportion of the total State and local criminal justice expenditures accounted for by each eligible jurisdiction.[38] The remaining 30 percent is divided equally among police, court administration, corrections and alternative processing projects. This money is distributed to local jurisdictions based upon their proportion of the total State and local expenditures for, respectively, law enforcement, judicial and related, correctional, and criminal justice expeditures.[39] For example, if 30 percent of the State grant amounted to $4,000, $1,000 would be allocated to police programs; if a large city accounted for 10 percent of the total law enforcement expenditures in the State, that city would receive $100 for police programs.

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[30] *Id.* at §403(b).
[31] *Id.* at §402(a)(2), (3).
[32] *Id.* at §402(a)(4).
[33] *Id.* at §402(a)(5).
[34] Office of Management and Budget, *The Budget of the United States Government, Fiscal Year 1980,* U.S. Government Printing Office, Washington, D.C., 1979, pp. 637–639.
[35] Phyllis Black, budget analyst, Office of the Comptroller, Law Enforcement Assistance Administration, telephone interview in Washington, D.C., Dec. 12, 1979.
[36] Ibid.
[37] Pub. L. No. 96–157 §405(a)(1), 93 Stat. 1167 (1979).
[38] *Id.* at §405(a)(3)(A).
[39] *Id.* at §405(a)(3)(B).

Comprehensive Employment and Training Act

The Comprehensive Employment and Training Act (CETA) of 1973, as reauthorized on October 27, 1978, by Public Law 95-524, decentralized decision-making authority for employment and training programs from the Federal Government to States and local jurisdictions.[1] The principal aim of the act is to "provide job training and employment opportunities for economically disadvantaged, unemployed and underemployed persons to enable them to secure self-sustaining, unsubsidized employment."[2] Prime sponsors (defined below under "Organizational Structure") are responsible for assessing local needs and developing program activities to meet those needs through a range of services that can include classroom instruction, on-the-job training, work experience, public service employment, counseling, testing, job development, child care, and other support.[3] Prime sponsors can arrange to provide these services directly or through contracts or subgrants with organizations such as the State employment service, vocational education agencies, community groups, and private firms.[4]

The act, as amended in 1978, has eight titles. Following is a summary of their basic provisions:

- Title I contains the general provisions governing the act, including the designation of State and local prime sponsors to administer the program, the planning and plan approval process, and special responsibilities of Governors and State and local advisory councils.[5]
- Title II combines the comprehensive training and employment services previously authorized under Title I and the public employment programs previously authorized under Title II.[6]
- Title III authorizes the Secretary of Labor to provide services to groups who experience particular disadvantages in the labor market. These include Native Americans, migrant and seasonal farmworkers, ex-offenders, older workers, the handicapped, women, single parents, displaced homemakers, individuals who lack educational credentials, and welfare recipients. Research and demonstration projects and labor market data collection are also authorized under this title.[7]
- Title IV continues the Youth Employment and Demonstration Projects Act of 1977 (except for the Young Adult Conservation Corps, which is in Title VIII), as well as the Job Corps and the summer youth program.[8]
- Title V establishes the National Commission for Employment Policy of 17 members appointed by the President. Nine members must be from nongovernmental agencies.[9]
- Title VI authorizes funding of the countercyclical public service employment (PSE) program to provide sufficient temporary public service jobs to employ 20 percent of the number of unemployed in excess of a 4 percent rate of unemployment. If the national unemployment rate is beyond 7 percent, the authorization increases to 25 percent. At least 50 percent of the Title VI funds must be used for employing persons in projects. Projects are defined as short term rather than ongoing efforts. Although they are limited to 18 months, they can be extended in some circumstances. Persons employed under Title VI, with the exception of those employed in projects, must be hired at entry level.[10]
- Title VII provides for the private sector initiative program (PSIP). This demonstration effort is designed to test the effectiveness of a variety of approaches to increasing the involvement of the business community in both employment and training.[11]
- Title VIII authorizes the Young Adult Conservation Corps initiated in the Youth Employment and Demonstration Project Act of 1977. This program provides up to 1 year of employment for out-of-school, unemployed persons 16 to 23 years of age. Preference is given to those residing in areas of substantial unemployment.[12]

[1] *Department of Labor Annual Report of FY 1978, Section 2 Program Performance*, p. 30.
[2] *Id.*
[3] *Id.*
[4] *Id.*
[5] 29 U.S.C. §812(1976).
[6] *Id.* §841.
[7] *Id.* §871.
[8] *Id.* §891.
[9] *Id.* §951(b), §952(a).
[10] *Id.* §961.
[11] *Id.* §981.
[12] *Id.* §991.

Organizational Structure

CETA is administered by the Employment and Training Administration (ETA), Department of Labor. The four most significant responsibilities of ETA regarding CETA are: establishing national objectives, priorities, and performance standards; providing technical assistance; reviewing and approving plans; and assessing and evaluating performance. Plan reviews are conducted within the 10 DOL/ETA regional offices.

CETA programs are administered through prime sponsors. Prime sponsors are State governments, city or county governments with populations over 100,000, or combinations of units of government called "consortia" in which at least one member jurisdiction has a population of over 100,000. The Secretary of Labor can designate additional sponsors on determining that they have a special capacity for carrying out CETA programs in certain labor markets or in rural areas with high unemployment; an Indian tribal council is a possible example. Currently, 473 prime sponsors operate CETA programs.[13]

Prime sponsors determine local needs and provide programs to meet them through the proper mix of allowable services. Sponsors may arrange to provide services directly or through contracts or subgrants with such organizations as the State employment service, vocational education agencies, community groups, or private organizations. They are also responsible for monitoring and evaluating programs to ensure that they meet local needs.

Benefits

The services allowable under CETA are comprehensive; they include:

- *Services to applicants,* including outreach, intake, and eligibility screening.[14]
- *Employment and training services,* including (but not limited to) orientation to the work world, counseling and testing, assessment of employability, job development, job search assistance, and job referral and placement.[15]
- *Supportive services,* including health care and medical services, child care, transportation, temporary shelter, assistance in securing bonds, family planning services, legal services, and financial counseling and assistance.[16]
- *Post-termination services* are provided to an individual for 30 days after termination of the program employment and training services and supportive services.[17]

In addition, "other activities" may be provided. These may include the removal of artificial barriers to employment (such as ramps, elevators, railings), job restructuring, the revision or establishment of merit systems, and the development and implementation of affirmative action plans.[18]

The mix of services selected by a prime sponsor is submitted to DOL/ETA in a comprehensive employment and training plan (CETP).[19] The CETP consists of two parts: the master plan, a long-term agreement between DOL and the prime sponsor,[20] and the annual plan, the yearly plan for providing services to eligible population.[21]

The act requires each prime sponsor to establish a planning council with representation from all segments of the community, including client groups and community-based organizations, the public employment services, education and training institutions, business, labor, and, where appropriate, agriculture.[22] The functions of the council are to submit recommendations on program plans, goals, policies, and procedures; to monitor and evaluate objectively employment and training programs in their jurisdiction; and to provide for continuing analysis of employment and training needs.[23]

Governors may receive formula grants under Titles II, IV, VI, and VII to provide services for the balance-of-State areas that do not fall within the jurisdictions of independent (local) prime sponsors. In addition, there are special grants of six percent of Title II-B funds to Governors for vocational training services in prime sponsor jurisidictions, 4 percent for coordination and special statewide employment and training services, 1 percent for staffing and support of the State employment and training services councils (SETSCs), and 1 percent of the

[13] Hugh Davies, Chief, Division of Program Planning and Design, ETA/DOL, interview in Washington, D.C., Dec. 7, 1979 (hereafter cited as Davies Interview).
[14] 20 C.F.R. §676.25-5(a)
[15] *Id.*
[16] *Id.*
[17] *Id.*
[18] *Id.* §676.25-6.
[19] *Id.* §676.9.
[20] *Id.*
[21] *Id.*
[22] *Id.* §676.7(a).
[23] *Id.* §676.7(d).

total Title II allocation for coordination with the education system.[24]

The SETSC, whose chairperson and members are appointed by the Governor, is authorized to review both the plans of each prime sponsor and the plans of State agencies providing services to these prime sponsors. The SETSC is also charged with monitoring the operations of the prime sponsors, monitoring State activities, and making recommendations to the Governor for improvements.[25]

CETA requires that at least one-quarter of the SETC membership be composed of representatives of units of general local government, one-quarter from labor and business, one-quarter of representatives from the eligible population served, and one-quarter of representatives of service deliverers.[26] The last must include, among others, representatives of community-based organizations.[27]

Eligibility

Eligibility requirements differ for each of the programs provided under the various titles.

Title II: To receive the training, education, work experience, upgrading, retraining and the countercyclical public service employment (PSE) services available under the title to prepare jobless persons for unsubsidized employment, participants must meet the following eligibility criteria: For the training programs and services (except for upgrading and retraining), participants must be economically disadvantaged and either unemployed, underemployed (i.e., persons working part time but seeking full-time work, or working full time but whose annualized salary is not above either the poverty level or 70 percent of the lower living standard income level),[28] or in school. Participants in Title II PSE programs must have been economically disadvantaged and unemployed 15 or more weeks or on welfare. Public service employment must be entry level and combined with training and supportive services. Supplementation of wages under this title is specifically prohibited.[29]

Title VI: This provides temporary public service employment opportunities during periods of high unemployment. Participants must be unemployed at least 10 of the last 12 weeks or on welfare and from a family whose income does not exceed the Bureau of Labor Statistics lower living standard budget. At least 50 percent of Title VI funds must be used for the employment of persons in projects. These must be limited to 18 months, but can be extended in some circumstances. Persons employed under Title VI, not employed in projects, must be hired at entry level.[30]

Title VIII: This provides employment and experience in various occupational skills to out-of-school young people, 16 to 23 years of age, from all social and economic backgrounds through work on conservation and other projects on Federal and non-Federal public lands and waters. Participants may be hired for up to 12 months.[31]

Funding

For the most part, the CETA program operates through block grants to the States and localities selected as prime sponsors. In fiscal year 1979 $4,431 million was available for Title II programs, $371.7 million for Title III, $1,750.2 million for Title IV, $3,475 million for Title VI, $500 million for Title VII, and $216.9 million for Title VIII.[32]

Whereas the program level, particularly for the Title VI PSE effort, was increased during the 1978 economic recession (enrollees were up to 750,000), by the end of FY 80 the number was reduced to 450,000. Therefore, the program capabilities with respect to domestic violence needs must be viewed in the context of this reduction.[33]

[24] Davies Interview.
[25] *Id.* §677.36.
[26] *Id.*
[27] *Id.* §677.36(b)(4)(ii).
[28] *Id.* §675.5-2.
[29] *Id.* §675.5-3.
[30] *Id.* §675.5-6.
[31] *Id.* §675.5-8.
[32] ETA/DOL, "Program Fact Sheet," December 1978.
[33] Davies Interview.

Food Donation Program

The food donation program was established to improve the diets of school children and other needy persons.[1] A second objective of the program is to utilize surplus or abundant commodities, whether in private stocks or acquired through the price support operations of the Commodity Credit Corporation.[2]

Several other Federal laws affect the distribution of commodities under this program. Sections 6, 9 and 14 of the National School Lunch Act enable food to be donated to schools participating in the school lunch program, as well as to other schools carrying out nonprofit school lunch programs.[3] The Agricultural Trade Development and Assistance Act of 1954, as amended, directs the Secretary of Agriculture to make surplus commodities available for distribution to needy families and persons in the United States before such commodities are made available for sale in foreign countries;[4] and sections 409 and 410(b) of the Disaster Relief Act of 1974 authorizes the Secretary to distribute surplus commodities to victims of a major disaster.[5]

Organizational Structure

The food donation program is administered through the Food and Nutrition Service (FNS) of the Department of Agriculture.[6] Program policy, procedures, and the issuance of regulations are decided at the Federal level.[7] Regional offices in the Department review and monitor the program as it operates in the States.[8]

Distributing agencies administer the program in the States.[9] "Distributing agencies" means State, Federal, or private agencies that enter into agreements with the Department for the distribution of commodities to eligible recipient agencies and recipients; a distributing agency may also be a recipient agency.[10] Distributing agencies vary from State to State (e.g., State welfare office, department of education, department of agriculture).[11] A State may choose to have more than one distributing agency to administer the various programs (e.g., schools, elderly, charitable institutions).[12] The responsibilities of State distributing agencies include:

(1) Determining eligibility of recipient agencies (or recipients;[13]

(2) Entering into agreements with subdistributing (agencies, recipient agencies, or other persons to whom commodities are distributed;[14]

(3) Submitting a plan for prior approval of the FNS, that (describes the proposed methods for determining the number of needy persons in charitable institutions;[15]

(4) Submitting a plan for prior approval of the FNS (that describes the proposed methods to be used in certifying households as being in need of food assistance;[16]

(5) Maintaining records regarding the receipt, disposal, (and inventory of donated food;[17] and

(6) Submitting monthly and annual reports to the FNS Regional Office.[18]

Benefits

Benefits under this program include food items and in some cases cash assistance. Food items may include surplus removal foods (e.g., fruits, vegetables, meat, and poultry) or price support foods (e.g., flour, oil, butter, peanut butter, dry milk, and rolled oats).[19]

[1] 7 C.F.R. §250, Agriculture, Subchapter B—General Regulations and Policies—Food Distribution, revised 1/1/78, 250.1(b)(1).
[2] *Id.*
[3] *Id.* §250.1(b)(6)(a).
[4] *Id.* §250.1(b)(9).
[5] *Id.* §250.1(b)(11).
[6] *Id.* §250.2.
[7] Marvin Eakin, Chief, Food Branch, Food Distribution, Department of Agriculture, telephone interview, Dec. 13, 1979 (hereafter cited as Eakin Interview).
[8] Jennifer Nelson, Acting Deputy Administrator, Special Nutrition Programs, Department of Agriculture, interview in Washington, D.C., Oct. 19, 1979.
[9] *Id.*
[10] 7 C.F.R. §250.3(e)(1978).
[11] Eakin Interview.
[12] *Id.*
[13] 7 C.F.R. §250.6(a)(1978).
[14] *Id.* §250.6(b).
[15] *Id.* §250.6(d).
[16] *Id.* §250.6(e).
[17] *Id.* §250.6(g).
[18] *Id.* §250.6(r).
[19] Darrel Grey, Director, Food Distribution Division, Special Nutrition Programs, Department of Agriculture, telephone interview, Oct. 25, 1979 (hereafter cited as Grey Interview).

Cash may be received, in lieu of commodities, by nutrition programs for the elderly and, under certain conditions, by child nutrition programs.[20] For nutrition programs for the elderly under Title III of the Older Americans Act, any State may elect cash payments instead of all, or any portion, of donated food it would otherwise receive.[21] Additionally, if a State has phased out its commodity distribution facilities before July 1, 1974, it may receive cash payments in lieu of donated food for programs conducted under the National School Lunch Act and the Child Nutrition Act of 1966.[22]

In situations of distress (usually situations such as group demonstrations),[23] in which needs for food assistance cannot be met under other provisions of the food donation program, any distributing agency may, upon request to and approval of the Secretary, distribute commodities to any institution, or to any association of persons engaged in charitable activities, for use in conducting temporary group feeding programs.[24]

Eligibility

Eligible Distributing Agencies

State and Federal agencies that are designated by the Governor of the State, by the State legislature, or by proper Federal authority and approved by the Secretary, are eligible to become distributing agencies.[25] If private agencies agree to make distribution of commodities on a statewide basis, they must apply directly to the Commodity Distribution Division, FNS, and be approved by the Secretary to be eligible to become a distributing agency.[26]

Eligible Recipient Agencies

Eligible recipient agencies may include schools, nonprofit summer camps, welfare agencies, disaster relief organizations, service institutions, nutrition programs for the elderly, nonresidential child-care institutions, Indian tribal organizations, and charitable institutions.[27]

Schools are defined as educational units of high school grade or operating under public or nonprofit private ownership in a single building or complex.[28] The definition includes public or nonprofit private residential child care insititutions. Schools that participate in the national school lunch program are eligible to receive commodities.[29]

Service institutions are nonresidential, public or private, nonprofit institutions or public or private, nonprofit, residential summer camps that serve children from areas in which poor economic conditions exist.[30] Disaster organizations are those authorized by appropriate Federal and State officials to assist disaster victims.[31] Nonresidential child-care institutions are defined as child-care centers, family and/or group day-care homes; and sponsoring organizations.[32]

Charitable institutions are defined as nonpenal, noneducational public institutions; nonprofit, tax-exempt private hospitals; or other nonprofit private institutions organized for charitable or public welfare purposes.[33] This definition excludes any institution which participates in any of the Department's child nutrition programs. They must maintain an established feeding operation on a regular basis as an integral part of their normal activities in order to qualify for the program. They must also recieve approval of the public welfare agency as meeting a definite community need by administering food to needy persons.[34]

Welfare agencies are defined as public or private agencies offering assistance on a charitable or welfare basis to needy persons who are not residents of an institution.[35] Tribal councils are those groups designated by the Bureau of Indian Affairs.

Individual Eligibility

Individuals eligible to receive donated food include: needy persons in households; disaster victims;[36] all children in school, child-care institutions, and summer camps participating in the program; all residents of charitable institutions that receive donated food; all elderly persons who participate in nutrition programs receiving donated food; and families living on or near an Indian reservation who

[20] 7 C.F.R. §250.1(b)(14)(1978).
[21] *Id.* §250.1(b)(15)(d-1).
[22] *Id.* §250.1(b)(18).
[23] Eskin Interview.
[24] 7 C.F.R. §250.13(1978).
[25] *Id.* §250.5(a).
[26] *Id.* §250.5(b).
[27] *Id.* §250.8.
[28] *Id.* §250.3(n).
[29] *Id.* §250.8(a).
[30] *Id.* §250.3(n-1).
[31] *Id.* §250.3(c).
[32] *Id.* §250.3(w).
[33] *Id.* §250.3(g).
[34] *Id.* §250.8(b).
[35] *Id.* §250.3(s).
[36] *Id.* §250.9.

are certified by the local welfare office as having inadequate income.[37]

Federal regulations state that recipient agencies may serve meals containing donated foods to persons other than those eligible when such persons share common preparation, serving, or dining facilities with eligible persons.[38]

[37] 7 C.F.R. §283, Administration of the Food Distribution Program to Households on Indian Reservations.
[38] *Id.* §250.10.

Funding

The funding level for the food donation program for 1980 was $890 million.[39] Of this amount, $26 million was allocated for charitable institutions.[40] The largest portion of the funding, $700 million, was allocated for schools.[41]

[39] Grey Interview.
[40] *Id.*
[41] *Id.*

Community Health Centers Program

The Health Services and Centers Amendments of 1978 to the Public Health Services Act (Public Law 95-626) provides current authorization for the community health centers program.[1] Section 330 of the act, which builds upon previous legislation, authorizes grants to public and private nonprofit entities for the provision of primary, supplemental, and environmental health services.[2]

In 1967, through section 314 of the Public Health Services Act, HEW received legislative authorization for the development of comprehensive health care programs focusing on areas with "scarce or non-existent health care services and populations with special health needs."[3] In 1968 funds were appropriated to HEW for the purpose of setting up neighborhood health centers (NHCs) based on a model initiated by the Office of Economic Opportunity (OEO).[4] The purpose of these centers was to provide comprehensive ambulatory health services to medically underserved populations. Furthermore, the centers were to coordinate Federal, State, and local resources into one organization having the capacity to provide a range of medical and related social services. The focus of the centers was on the delivery of health care in urban areas.[5] In 1971, to complement the services of NHCs and to meet the need for delivering health care services in rural areas, the family health center model was conceived. The purpose of these centers was to provide a prepaid package of health care services to poor persons living in a "defined area of medical underservice."[6] While the family health care model was becoming operational, the neighborhood health centers were being expanded through transfer of administrative responsibility from OEO to HEW.[7]

In 1975 section 314e was repealed with the enactment of the Health Revenue Sharing and Health Services Act, which amended the Public Health Service Act and gave detailed authority to HEW for the community health centers program.[8] In 1978 further amendments to the Public Health Services Act provided the legislative authority for the current community health centers program.[9]

Organizational Structure

At the Federal level, the Bureau of Community Health Services in the Health Services Administration of the Public Health Service, Department of Health, Education, and Welfare is responsible for the administration of the community health centers program.[10] The Bureau has two major goals: development of capacity building and development of State systems of assurance.[11]

The purpose of capacity building is to improve the "accessibility, availability and quality of primary care services through optimal utilization and integration of health resources" in underserved urban and rural areas.[12] Capacity building is based on the community health centers program, along with the migrant health program, National Health Services Corps, Appalachian demonstration health programs, health underserved rural areas program, and home health services program.[13]

The goal of the State systems of assurance is to increase the States' responsibilities for providing quality care for their populations. Under this program are family planning clinics, and the maternal and child health, genetics, and hypertension programs.[14]

The Bureau headquarters is responsible for policy, allocation of grant monies to regional offices, and data collection.[15] In each of the 10 regional offices of the Public Health Service, the Bureau maintains a unit called the Division of Health Services Delivery. These units oversee the operations of the community

[1] 42 U.S.C. §254c (West Supp. 1974-1978).
[2] *Id.*
[3] 1978 U.S. Code Cong. & Ad. News 9201.
[4] *Id.*
[5] *Id.*
[6] *Id.*
[7] *Id.*, at 8.
[8] *Id.*
[9] 42 U.S.C.A. §254c (West Supp. 1974-1978).
[10] Bob Martens, program analyst, Community Health Center Program, Division of Policy Development, Bureau of Community Health Services, Department of HEW, interview in Rockville, Md., Oct. 19, 1979 (hereafter cited as Martens Interview).
[11] Deborah Haffner, public health analyst, Office of Primary Care, Bureau of Community Health Services, Department of HEW, interview in Rockville, Md., Oct. 19, 1979 (hereafter cited as Haffner Interview).
[12] U.S., Department of Health, Education, and Welfare, *Bureau of Community Health Services Programs* (DHEW Pub. No. (HSA) 78-5002, 1978), p. 3, (hereafter cited as DHEW, *BCH Services Programs).*
[13] Haffner Interview.
[14] *Id.*
[15] Martens Interview.

health centers programs, as well as of other Bureau programs. They also review and approve grant applications and monitor existing programs.

For fiscal year 1980 it is anticipated that 804 local community health centers will be in operation throughout the country, serving more than 4.3 million people.[16]

By law local programs receiving planning and development or operation grants must be administered by a governing board.[17] According to the regulations, the board will normally have no less than 9 and no more than 25 members.[18] Members of the board are to be predominately individuals served by the center and representative of the population the center serves.[19] The responsibilities of the governing board include establishing policy for the center, selecting services the center will provide, scheduling hours of business, approving the annual budget, and selecting the center's director.[20] The governing board requirements differ for community health projects. Projects are not required to have a governing board until completion of their first year of operation.[21] Furthermore, the current legislation changes governing board requirements for public centers:[22] the requirements regarding financial management, personnel policy and some policy decision-making authority have been waived for public centers.[23]

Benefits

The legislation stipulates that centers provide the following services to residents of catchment areas, either directly or through other public or private nonprofit entities:[24]

(1) *Primary health services.* These include: the services of physicians and, where feasible, physicians' assistants and nurse practitioners; diagnostic, laboratory, and radiologic services; preventive health services, including children's eye and ear examinations, prenatal services, well-child services, and family planning services; emergency medical services; transportation services as required for adequate patient care; preventive dental services; and pharmaceutical services as appropriate for particular centers.[25]

(2) *Supplemental health services.* These services will be provided when it has been determined by the Secretary that such services are "necessary for the adequate support of primary health services." These services include: hospital services; extended care services; rehabilitative services, including physical therapy and long-term physical medicine; mental health services; dental services; vision services; allied health services; therapeutic radiologic services; public health services including (for social and other nonmedical needs that affect health) counseling, referral for assistance, and followup services; ambulatory surgical services; health education services, including nutrition education;[26] and services promoting and facilitating "optimal use of primary health services," including, "if a substantial number of individuals in the population served by a community health center are of limited English-speaking ability, the services of appropriate personnel fluent in the language spoken by a predominant number of such individuals."[27]

(3) *Referral services.* These include referral to and payment for supplemental health services when "appropriate and feasible."[28]

(4) *Environmental health services.* These include the "detection and alleviation of unhealthful conditions associated with water supply, sewage treatment, solid waste disposal, rodent and parasitic infestation, field sanitation, housing, and other environmental factors related to health."[29]

(5) *Information services.* These services include information on the availability and proper use of health services.[30]

Project funds can be used for, but are not limited to: acquiring and modernizing existing buildings, delivering health services, training costs, and technical assistance related to provision and management of service delivery. Additionally, project funds can be used to reimburse governing board members for

[16] Linda Martens, staff assistant, Community Health Centers Program, Bureau of Community Health Services, Department of HEW, telephone conversation, Dec. 6, 1979.
[17] 42 U.S.C. §254c(e)(3)(G)(West Supp. 1974–1978).
[18] 42 C.F.R. §51c 304(a)(1979).
[19] 42 U.S.C. §254(c)(e)(3)(G)(West Supp. 1974–1978).
[20] *Id.*
[21] 42 C.F.R. §51c 304(a) (1979).
[22] 42 U.S.C.A. §254c(e)(3)(G)(West Supp. 1974–1978).
[23] Martens Interview.
[24] 42 U.S.C. §254c(a)(West Supp. 1974–1978).
[25] *Id* §254c(b)(1)(A–G).
[26] *Id.*
[27] *Id.*
[28] *Id.* §§(a)(3).
[29] *Id.*
[30] *Id.* §§(a)(5).

related expenses, as well as for wages lost due to participation on governing boards.[31]

The amount of a grant cannot be greater than the amount by which the operating costs exceed reimbursements that the center may expect to receive for its operation during the fiscal year.[32] No more than two planning and development grants may be awarded to the same project.[33]

Eligibility

Eligibility for Grants

Any public or nonprofit private entity (agency, institution, or organization) is eligible to apply for grant money to provide health services in an area designated as medically underserved.[34] A medically underserved area is either a population or a population group in a rural or urban area in which there is a "shortage of personal health services."[35] At present, there are approximately 7,000 medically underserved areas in the country.[36] According to the regulations,[37] these areas are periodically designated by the Secretary of HEW using the following indicators: "available health resources" in relationship to size and population of a given area;[38] "health indices for the population area, such as infant mortality rate";[39] economic factors affecting access to health services such as the percentage of the population below poverty level;[40] and demographic factors affecting "need and demand for health services such as the percentage of the population over 65."[41]

Applications for grants may be submitted any time to the appropriate HEW regional office. Applications are also subject to State and local review.[42]

Grant money is available for basically two purposes: (1) planning and development of community health centers, and (2) operating existing centers or operating projects that do not meet all the specific legislative requirements for centers.[43]

Applications for planning and development grants must include an assessment of the needs of the population to be served for primary, supplemental, and environmental health services[44] and a design for a health program to meet the assessed needs.[45] Furthermore, applicants should make an effort to secure "financial and professional assistance" for the project,[46] as well as to initiate and encourage "continuing community involvement in the development and operation of the project.[47] Planning and development grants may include the costs of acquiring and modernizing existing buildings.[48]

Applications for operating grants must include a description of the service population's need for environmental home health, dental, and health education services.[49] If the applicant determines that any such service is not needed, the basis for such determination must be given.[50] Similarly, a reason must be provided if funds are not requested for any service which the applicant determines is needed.[51] Also, in areas with a substantial group of persons with limited English-speaking ability, the center or project must have "personnel fluent in the language spoken by a predominate number of such individuals."[52]

Centers must meet the following requirements:

- Ensure that primary health services will be available after funds are awarded;[53]
- Provide an ongoing quality assurance program;[54]
- Maintain the confidentiality of patient records;[55]
- Demonstrate their financial responsibility using proper financial procedures;[56]
- Provide for contractual or other arrangements with appropriate agencies for the payment of center costs of serving persons eligible for medicare or medicaid;[57]

[31] 42 C.F.R. §51c 107 (b)(1-8)(1979).
[32] 42 U.S.C. §254c(d)(4)(A)(West Supp. 1974-1978).
[33] *Id.* §(c)(2).
[34] *Id.* §§(a) and (b)(3).
[35] *Id.* §§(b)(3).
[36] Haffner Interview.
[37] 42 C.F.R. §51c 102(e)(1979).
[38] *Id.*
[39] *Id.*
[40] *Id.*
[41] *Id.*
[42] Haffner Interview.
[43] 42 U.S.C.A. §254c(e)(1) and (d)(1)(A)(B)(West Supp. 1974-1978).
[44] *Id.*
[45] 42 U.S.C. §254c(e)(1)(B).
[46] 42 U.S.C. §254c(e)(1)(C).
[47] 42 U.S.C. §254c(e)(1)(D).
[48] 42 U.S.C. §254c(e)(1)(West Supp. 1974-1978).
[49] *Id.* §§(e)(2)(A).
[50] *Id.*
[51] *Id.*
[52] *Id.*
[53] *Id.* §§(e)(3)(A).
[54] *Id.* §§(e)(3)(B).
[55] *Id.*
[56] *Id.* §§(e)(3)(C).
[57] *Id.* §§(e)(3)(D).

- Make a reasonable effort to collect reimbursement for costs in providing health care to persons receiving public or private insurance benefits;[58]
- Establish a fee and discount schedule based on the clients' ability to pay and attempt when appropriate to collect reimbursement for health services delivered;[59]
- Establish a governing board;[60]
- Develop an overall plan and budget in compliance with established guidance and procedures;[61]
- Review their catchment areas periodically to assure that center services are maximally accessible; that catchment boundaries adhere when practical to relevant political subdivision boundaries, school districts, and Federal and State health and social service programs; and that boundaries eliminate barriers to access whenever possible;[62]
- Develop a plan to serve the special needs of persons of limited English-speaking ability if that population comprises a significant portion of the catchment area;[63] and
- Provide for ongoing referral relationship with one or more hospitals.[64]

All grants, planning and development and operational, are awarded to those applicants and proposals that are determined to "best promote" the purposes of the legislation.[65] The following factors are taken into consideration:

- The degree to which the plan meets stated requirements;[66]
- The relative need of the population to be served;[67]
- The "administrative and management" capability of the applicant;[68]
- The project's potential for developing "new and effective methods for health service delivery and management";[69]
- The soundness of the fiscal plan;[70]
- The extent that community resources will be used;[71]
- The extent to which grants approved will provide for "appropriate distribution of resources throughout the country";[72]
- Whether the catchment area of the project is exclusive of the area served by the community health center; and[73]
- The degree to which the applicant plans to *integrate* services with already existing health resources.[74]

Additionally, in awarding operational grants, consideration is given to the number of center users and the "level of utilization in previous operational periods,"[75] the extent that preventive health services will be used to "maintain and improve the health status of the population served,"[76] and the extent that centers "emphasize direct health services, efficiency of operations and sound financial management."[77]

Individual Eligibility

Individual eligibility for community health center services is based on residence in the specified catchment area that the center serves.[78] Centers must prepare a fee schedule based on the patient's ability to pay for services.[79] Free services will be provided to individuals and families who are at, or below, the most recent Community Services Administration poverty income guidelines. Individuals and families whose incomes are twice that established in the guidelines are required to pay the full cost of services.[80]

Funding

Funds authorized for planning and development grants for fiscal year 1979 were $6.3 million and for fiscal year 1980, $7.5 million.[81] Operating grants authorized for fiscal year 1979 amounted to $341.7 million and for fiscal year 1980, $397.5 million.[82] In actuality, only $277 million was appropriated for operating grants in fiscal year 1979 and it was

[58] *Id.* §§(e)(3)(E).
[59] *Id.* §§(e)(3)(F).
[60] *Id.* §§(e)(3)(G).
[61] *Id.* §§(e)(3)(H).
[62] *Id.* §§(e)(3)(I).
[63] *Id.* §§(e)(3)(J).
[64] *Id.* §§(e)(3)(K).
[65] 42 C.F.R. §51c 204(a) and 305(1979).
[66] *Id.* §§ 204(a)(1) and 305(a).
[67] *Id.* §§204(a)(2) and 305(b).
[68] *Id.* §§ 204(a)(4) and 305(c).
[69] *Id.* §§ 204(a)(5) and 305(d).
[70] *Id.* §§ 204(a)(6) and 305(j).
[71] *Id.* §§ 204(a)(7) and 305(f).
[72] *Id.* §§ 204(a)(8) and 305(h).
[73] *Id.* §§ 204(a)(9) and 305(i).
[74] *Id.* §§ 305(g).
[75] Martens Interview.
[76] 42 C.F.R. §51c 305(k).
[77] 42 C.F.R. §51c 305(i).
[78] 42 U.S.C. §254c(e)(3)(F)(i)(West Supp. 1974–1978).
[79] 42 U.S.C. §254c(g)(1)(West Supp. 1974–1978).
[80] 42 C.F.R. §51c 303(f)(1979).
[81] *Id.* §§(g)(2).
[82] Martens Interview.

anticipated that only $341.5 million would be appropriated in fiscal year 1980.[83] Monies go to the regional offices according to a complex allocation formula taking into consideration the number of centers supported, the number of applications for funding, and the productivity (according to specific indicators) of existing centers. Other pertinent priorities of the Bureau may also be considered.[84] The amount of an awarded grant will be based on an estimation of the funds necessary for a "'designated portion" of direct and indirect project costs[85] and the amount of income a program generates.[86]

[83] *Id.*
[84] 42 C.F.R. §51c (106)(a)(1979).
[85] Martens Interview.
[86] Martens Interview.

Community Action Programs

Community action programs (CAPs) are authorized under the Economic Opportunity Act of 1964,[1] as amended. CAPs are community-based programs providing a range of services and activities designed to have a major impact on the causes of poverty. The fundamental purpose of CAPs is "to stimulate a better focusing of all available local, State, private, and Federal resources upon the goal of enabling low-income families, and. . .individuals. . .in rural and urban areas, to attain the skills, knowledge, and motivations and secure the opportunities needed for them to become fully self-sufficient."[2] Another purpose is to enable impoverished persons residing in rural areas to remain in such areas and become self-sufficient.[3]

The primary means for the administration of CAPs is the community action agency (CAA). A CAA may either be a public or private nonprofit agency or organization.[4] Through their governing boards, CAAs are given wide discretion to plan, implement, and evaluate services and activities designed to attack the problems of impoverished people.[5]

There are 878 CAAs serving 2,212 of the Nation's 3,141 counties. These counties contain 75 percent of the Nation's population and about 90 percent of the poor. These CAAs serve an estimated 16 million, or 64 percent, of the Nation's 25 million poor.[6]

Organizational Structure

Federal Administration

The Federal administration agency for community action programs is the Community Services Administration (CSA), the successor agency to the Office of Economic Opportunity.[7] The CSA also administers the broad range of programs covered by the Economic Opportunity Act of 1964, as amended. The Office of Community Action in CSA has the direct administrative responsibility for CAPs.[8] CSA operates offices in all 10 Federal regions.

Assisting CSA in its overall administrative responsibilities is a National Advisory Council on Economic Opportunity.[9] The Advisory Council is composed of 21 members appointed for staggered terms of office by the President.[10] The purpose of the Advisory Council is to: advise the CSA Director on policy matters, review the operations and effectiveness of CSA programs, and make recommendations to improve programs, eliminate the duplication of programs, and coordinate CSA programs with other Federal programs serving low-income persons.[11]

State Administration

Each State has a designated agency (State economic opportunity office) that is responsible for:

(1) Providing technical assistance to communities and local agencies in developing and carrying out community action programs;

(2) Coordinating CAP activities at the State level;

(3) Advising and assisting the Director of the CSA in developing procedures and programs to promote the participation of States and State agencies in CAPs; and

(4) Assisting in identifying problems posed by Federal statutes or regulations that impede State-level coordination of CAPs and in developing recommendations for overcoming those problems.[12]

Local Administration

The CAA administers community action programs at the State or local level.[13] A CAA may be a State or local unit of government or a public or private nonprofit agency or organization designated

[1] 42 U.S.C. §§2701-2995b (1976).
[2] 42 U.S.C. §2781(a) (1976).
[3] 42 U.S.C.A. §2781(b) (Supp. 1979).
[4] 42 U.S.C.A. §2790(a) (Supp. 1979).
[5] 42 U.S.C. §2795. (1976).
[6] U.S., Community Services Administration, *Investing in Tomorrow: Progress Against Poverty* (FY 78 Annual Report) (hereafter cited as *FY 78 CSA Annual Report*), p. 9.
[7] 42 U.S.C.A. §2941 (Supp. 1979).
[8] *FY 78 CSA Annual Report*, p. 48.
[9] 42 U.S.C. §2945 (1976), as amended by Pub. L. No. 93-644, §9(c)(3), 88 Stat. 2314; Pub. L. No. 95-568, §13(c), 92 Stat. 2435.
[10] *Id.*
[11] *Id.*
[12] 42 U.S.C.A. §2824 (Supp. 1979).
[13] 42 U.S.C.A. §2790 (1976), as amended by Pub. L. No. 93-644, §5(a), (b), 88 Stat. 2294; Pub. L. No. 94-341, §2(a), 90 Stat. 803; Pub. L. No. 95-568, §§4(a), (b), 17(a)(3), 92 Stat. 2425, 2439.

to act as a CAA by either a State or local unit of government or an Indian tribal government.[14] The CAA is responsible for all phases of the planning, implementation, administration, and evaluation of a CAP.[15] A specific responsibility is to initiate and sponsor "projects responsive to the needs of the poor which are not otherwise being met, with particular emphasis on providing central services that can be drawn upon by a variety of related programs. . . ."[16] CAAs are also responsible for "developing new approaches or new types of services that can be incorporated into other programs, and filling gaps pending the expansion or modification of those programs."[17]

Each community action agency must have a governing board of not more than 51 members, consisting of: one-third elected public officials; at least one-third representatives of the poor being served by the agency (selected in a democratic manner); and the remainder being representatives from business, industry, labor, religious, welfare, education, or other major groups and interests in the community.[18] Board members (other than elected public officials) are limited to a term of service of no more than 5 consecutive years and total service of 10 years.[19]

Benefits

Program Assistance

Grants to CAAs

The Director of the CSA is authorized to provide grants to CAAs for the planning, conduct, administration, and evaluation of CAPs.[20] A community action program may involve activities and supporting facilities to assist program participants to:

(1) Secure and retain meaningful employment;
(2) Attain an adequate education;
(3) Use available income more effectively;
(4) Provide and maintain adequate housing and a suitable living environment;
(5) Undertake voluntary family planning;
(6) Obtain services for the prevention of narcotics addiction and alcoholism and for the rehabilitation of narcotics addicts and alcoholics;
(7) Obtain emergency assistance through loans or grants to meet immediate and urgent needs, including the need for health services, nutritious food, housing, and employment-related assistance;
(8) Remove obstacles and solve personal and family problems that block the achievement of self-sufficiency;
(9) Achieve greater participation in community affairs; and
(10) Make more frequent and effective use of other programs serving the poor.[21]

Grants to CAAs or Non-CAA-Operated Programs

The Director of the CSA has the authority to provide several forms of grants both to CAA and non-CAA programs.

Non-CAA Project or Program Grants

Where a CAA does not exist (or an existing CAA grants its approval), and the Director of the CSA determines there is a need for a limited purpose project, or program (otherwise eligible for funding as a CAP), a direct grant may be made to a public or private nonprofit agency to carry out the project or program.[22]

Special Programs

The Director of the CSA is authorized to make grants to CAAs or public or private nonprofit agencies to carry out special programs designed to meet a set of particular problems of the poor.[23] The special programs authorized are:

- *Community Food and Nutrition:* emergency financial assistance to counteract conditions of starvation and malnutrition among the poor.
- *Senior Opportunities and Services:* programs to meet the special needs of impoverished persons above the age of 60.
- *Environmental Action:* programs that pay low-income persons for work on projects to combat pollution or to improve the environment.
- *Rural Housing Development and Rehabilitation:* programs to help low-income families in rural areas to construct, buy, repair, or rehabilitate present housing or otherwise acquire standard housing.

[14] *Id.*
[15] *Id.*; 42 U.S.C. §2795 (1976).
[16] 42 U.S.C. §2795(b)(3) (1976).
[17] *Id.*
[18] 42 U.S.C.A. §2791(b) (Supp. 1979).
[19] *Id.*
[20] 42 U.S.C.A. §2808(a) (Supp. 1979).
[21] *Id.*
[22] 42 U.S.C.A. §2808(b) (Supp. 1979).
[23] 42 U.S.C.A. §2809(a) (Supp. 1979).

• *Emergency Energy Conservation Services:* programs to allow the poor and near-poor to use energy conservation materials in their homes.
• *Summer Youth Recreation:* programs to provide recreational opportunities for low-income youths during the summer.
• *Demonstration Employment and Training Opportunities:* experimental employment and training projects for the unemployed or underemployed, with special emphasis on youths, the structurally unemployed, single heads of households with dependent children, older workers, and veterans.[24]

State Agency Assistance

The Director of the CSA is authorized to make grants to State agencies to develop, coordinate, provide technical assistance, and otherwise assist in carrying out CAPs funded in the State.[25]

Special Assistance

Grants may be made to public or private nonprofit agencies operating projects that serve low-income groups not being effectively served by other programs receiving CAP funds. Special consideration is to be given to programs serving older persons and other low-income individuals who do not reside in low-income areas and are not being effectively served by other CAP-funded programs.[26]

Technical Assistance and Training

CSA may provide, directly or through grants or other arrangements, technical assistance and training for purposes of developing, conducting, and administering CAPs.[27]

Research and Pilot Programs

CSA is authorized to contract or provide financial assistance for pilot or demonstration projects conducted by public or private agencies which test or develop new approaches or methods that will aid in overcoming special problems or otherwise further the purposes of CAPs. Financial assistance to do research pertaining to the purposes of CAPs may also be granted.[28] Pilot or demonstration projects, and all research activities, must be carried out in accordance with an annual plan and efforts must coordinate with other Federal programs with similar objectives.[29]

Design and Planning Assistance Programs

CSA is required to make grants to or enter into contracts with nonprofit organizations providing architectural design and community planning services to community organizations and persons unable to afford such services. Priority must be given to communities with substandard housing, substandard public service facilities, and generally blighted conditions.[30]

National Youth Sports Program

CSA is required to make grants or enter into contracts for the conduct of a national youth sports program to allow low-income youth to receive recreation, educational, and counseling services.[31]

Consumer Action and Cooperative Programs

CSA is required to make grants or enter into contracts to provide consumer education services to low-income persons.[32]

Demonstration Community Partnership Agreements

CSA is authorized to provide matching financial assistance to CAAs or public or private nonprofit agencies to permit implementation of new programs serving the poor or to expand the services of existing programs. The local share of the matching funds must be in cash and represent new monies for the expansion of existing programs.[33]

Recipient Assistance

Low-income residents of an area served by a CAA, or a CAP, may receive benefits from any of the above programs that meet their needs.

Eligibility

Organizational

CAAs or public and private nonprofit agencies providing programs or activities meeting the needs of the poor are eligible to receive the benefits provided by community action programs. If a CAA is a private, nonprofit agency or organization, it

[24] *Id.*
[25] 42 U.S.C.A. §2824 (Supp. 1979).
[26] 42 U.S.C. §2827 (1976).
[27] 42 U.S.C.A. §2823 (Supp. 1979).
[28] 42 U.S.C.A. §2825 (Supp. 1979).
[29] *Id.*
[30] 42 U.S.C.A. §2813 (1976).
[31] 42 U.S.C.A. §2814 (Supp. 1979).
[32] 42 U.S.C. §2815 (1976).
[33] 42 U.S.C.A. §2828 (Supp. 1979).

must be designated by the State as the CAA serving a particular community.[34] Applications for any form of CAP grant must be approved by the Governor of a State before CSA approval of the application is granted.[35]

Recipients

CAPs serve individuals and families whose income is below 125 percent of the poverty income guidelines established by the Social Security Administration. The guidelines are adjusted for family size and rural or nonrural living conditions. Separate guidelines are established for Alaska and Hawaii.[36]

[34] 42 U.S.C. §2790(a) (Supp. 1979).
[35] 42 U.S.C. §2834 (1976).
[36] *FY 78 CSA Annual Report*, p. 3. (See note 8.)

Funding

In fiscal year 1978 CAP activities were funded as follows: $364.1 million primarily to CAAs, $200 million for emergency energy assistance, $29 million for community food and nutrition, $10.6 million for senior opportunities and services, $6 million for summer youth recreation, $6.2 million for rural housing and rehabilitation, $5.5 million for research and demonstration, $2 million for evaluation, and $1.2 million for training and technical assistance.[37] In addition to the funds received directly from CSA, CAAs were able to mobilize more than $1 billion in other Federal funds and more than $300 million in cash and in-kind services from State or local public and private agencies.[38]

[37] Ibid.
[38] Ibid.

Volunteers in Service to America (VISTA)

The VISTA program is authorized under the Domestic Volunteer Service Act.[1] Its purpose is to supplement efforts to eliminate poverty-related human, social, and environmental problems. To achieve this objective, VISTA enables individuals to perform meaningful and constructive service as volunteers in situations designed to help the poor overcome the debilitating effects of poverty and secure opportunities for self-advancement.[2]

The VISTA program rests on three basic assumptions:

(1) That private citizens can, on a voluntary basis, contribute to the solution of the Nation's domestic poverty problems;[3]

(2) That the skills and energies of volunteers are used more effectively when the volunteers live and work with the low-income people they are serving;[4] and

(3) That the full-time presence and personal involvement of volunteers bring an added dimension to the public and private institutions working to eliminate poverty.[5]

The volunteer's role in the poverty problem-solving process is directed toward mobilizing community resources and increasing the capacity of the target community to solve its own problems.[6] VISTA develops and coordinates a merging of the interests and efforts of three groups: the low-income community, the sponsoring organization, and the volunteers themselves.[7]

Organizational Structure

VISTA is administered by ACTION,[8] which also has responsibility for three other domestic volunteer programs (foster grandparents, the national student volunteer program, and the retired senior volunteer program) as well as the foreign services provided through the Peace Corps.[9] Within ACTION, the Division of Domestic Operations is charged with the administration of the VISTA programs.

ACTION has 10 regional offices that administer the ACTION domestic programs.[10] In each State, a State director is responsible for carrying out the priorities set by the regional office.[11] Decisions concerning the selection of sponsors and the assignment of volunteers are made at the State level.[12]

Benefits

Benefits of this program are not defined in terms of concrete direct services.[13] The program is not designed to eradicate poverty, but to strengthen and supplement ongoing community efforts to do so.[14] VISTA resources can increase access of the poor to information about available benefits and strengthen mechanisms for the securing of those benefits.[15] Through VISTA, volunteers have the opportunity to develop and transfer their information and skills to community leaders and residents in a manner that maximizes volunteer efforts.[16]

Eligibility

Eligible sponsoring organizations may include Federal, State, or local agencies or private, nonprofit organizations that are committed to solving problems directly related to the conditions of poverty.[17] The sponsoring organization must ensure that proposed projects achieve the following: the active participation of members of the low-income community in planning, developing, and implementing the project to ensure that it is responsive and relevant to the low-income citizens to whom it is addressed;[18] the mobilization of community resources;[19] and the eventual phase-out of the VISTA volunteer and the absorption of the volunteer's duties by other organizations in the community.[20]

[1] 42 U.S.C. §4951–5085 (1976).
[2] *Id.*
[3] VISTA Handbook No. 4301.1 (July 1, 1975), p. 1.
[4] Ibid.
[5] Ibid.
[6] Ibid.
[7] Ibid.
[8] 42 U.S.C. §5401 (1976).
[9] VISTA Handbook No. 4301.1, p. 2.
[10] Ibid.
[11] Torrie Mattas, policy analyst, ACTION, interview in Washington, D.C., Oct. 19, 1979.
[12] Ibid.
[13] VISTA Guidance Papers (Office of the VISTA Director, March 1978), p. 7.
[14] Ibid. p. 3.
[15] Ibid.
[16] Ibid.
[17] VISTA Handbook No. 4301.1, p. 1.
[18] Ibid.
[19] Ibid., p. 2.
[20] Ibid.

Potential sponsors contact the ACTION State office to apply for volunteers.[21] Preliminary applications are sent to the State director, who determines if the project is in compliance with VISTA guidelines.[22] Those projects judged to be in compliance are asked to complete a more detailed application.[23] Organizations selected as VISTA sponsors sign a memorandum of agreement with ACTION/VISTA that clearly defines the mutual responsibilities, the role of the volunteer, and anticipated accomplishments.[24]

Projects are selected for placement of VISTA volunteers if the placement will lead to an increased voice for low-income people in the decisionmaking processes that affect their lives.[25] Though projects differ in their approaches, the following elements should be present:

(1) The sponsoring agency should operate at the grassroots level, or the project should lead to the building or strengthening of a grassroots organization or advocacy system.[26]

(2) The volunteer's role should be one of support; direct services can be performed only if the provision of that service is part of an overall organizing strategy *and* if it is clearly demonstrated that the service, once established, can either be supported without VISTA resources or will not need to continue.[27]

[21] Ibid.
[22] VISTA Guidance Papers, p. 12.
[23] Ibid.
[24] VISTA Handbook No. 4301.1, p. 2.
[25] VISTA Guidance Papers, p. 1.
[26] Ibid., p. 2.
[27] Ibid., p. 7.
[28] VISTA Handbook No. 4301.1, p. 3.
[29] Ibid.

VISTA volunteers pledge to serve on a full-time basis for a term of at least 1 year, in addition to training time.[28] During their term of service, volunteers live among and at the economic level of the people served.[29] They remain available for service without regard to regular working hours, except for periods of leave.[30] There are two methods of recruiting full-time volunteers: locally, from the community in which they will serve, and nationally, from all over the country.[31] To be eligible as volunteers applicants must be citizens of the United States or permanent residents, over 18 years of age, and qualified on the basis of skills needed by the community.[32]

Whenever feasible, low-income community volunteers shall be assigned in their home communities.[33] Prior to assignment of any volunteer, he or she is provided an individual plan to provide an opportunity for job advancement or for transition to a situation leading to gainful employment.[34]

Funding

On December 13, 1979, the President signed into law the Domestic Volunteer Service Act Amendments of 1979,[35] a bill extending the authorization for domestic programs of ACTION through fiscal year 1981. The authorization for appropriation of funds for VISTA reads "such sums as may be necessary."

[30] Ibid.
[31] Ibid., p. 2.
[32] Pat Pickering, manager, Public Response Section, ACTION, telephone interview, Washington, D.C., Dec. 12, 1979.
[33] 42 U.S.C. §4953(b) (1976).
[34] *Id.*
[35] Domestic Volunteer Service Act Amendments of 1979, Pub. L. No. No. 96-143, 93 Stat. 1074 (1979).

Veterans Administration, Hospitalization and Outpatient Services Program

The Veterans Administration (VA) was established to carry out the provisions of Title 38 of the United States Code. Title 38 was enacted to provide certain benefits to persons who served in the active military, naval, or air services and who were discharged or released under conditions other than dishonorable and to the dependents and survivors of these veterans.[1]

Programs available to veterans include medical services, hospitalization, outpatient services, educational assistance, home loans, life insurance, and vocational rehabilitation.[2] This discussion focuses on hospitalization and outpatient programs.

The Veterans Administration currently maintains 172 hospitals with an 85,000-bed capacity that serve approximately 1.3 million inpatients annually.[3] In addition, these hospitals receive a yearly average of 17 million visits for counseling and outpatient services.[4] The VA operates 16 domicillaries and 88 nursing care units.[5] Eligible veterans may also receive care at the expense of the VA in non-VA hospitals, State home hospitals, and community nursing homes.[6]

Organizational Structure of the Department of Medicine and Surgery

One of the departments within the Veterans Administration is the Department of Medicine and Surgery, which operates under the Chief Medical Director. The Department's main function is to provide medical and hospital services for veterans.[7] It includes the following divisions: Medical Service, Dental Service, Podiatric Service, Optometric Service, and Nursing Service, as well as other professional and auxiliary services that the Administrator of the VA determines to be necessary to carry out the functions of the Department.[8] The Division of Social Work also falls under the direction of the Department of Medicine and Surgery and employs 3,600 social workers.[9]

The VA Administrator and Chief Medical Director are located in the Veterans Administration's central office in Washington, D.C. Each of the 172 hospitals in the VA health care system has a director who reports to the Chief Medical Director.[10]

The Administrator is authorized to appoint a special medical advisory group composed of members of the medical, dental, podiatric, optometric, and allied scientific professions who have been nominated by the hospitals' medical directors. These individuals advise the Chief Medical Director on the care and treatment of veterans, as well as other matters pertinent to the Department of Medicine and Surgery.[11] The Administrator is also authorized to establish multidiciplinary committees to advise the Administrator and Chief Medical Director on policies and programs relative to contractors with the VA, such as schools, public agencies, organizations, and other such institutions.[12] The current Administrator and his central office staff rely upon expert consultants for specific program and policy needs in addition to the advisory committees referred to above. Although it is not mandated, local hospitals may also appoint advisory committees.[13]

Benefits

Benefits under the hospitalization and outpatient services programs that are available to certain veterans and their dependents include:

Hospitalization and Outpatient Services

Eligible veterans and certain dependents and survivors may be provided a full range of inhospital services, as well as outpatient clinical services, by the Department of Medicine and Surgery.

[1] 38 U.S.C. §201 (Supp. 1979).
[2] 38 U.S.C., introduction, at 15.
[3] 38 U.S.C., introduction, at 6.
[4] Sawchak interview, Public Information Office, Veterans Administration Central Office, Washington, D.C., Nov. 27, 1979.
[5] *Id.*, p. 6.
[6] *Id.*, p. 7.
[7] 38 U.S.C. §4101(1976).
[8] *Id.*, §4102.
[9] Carlton Engquist, former Director , Social Work Services, Veterans Administration, interview Washington, D.C. Nov. 30, 1979 (hereafter cited as Engquist Interview).
[10] Ibid.
[11] 38 U.S.C. §4112(a)(1976).
[12] *Id.*
[13] Engquist Interview.

Readjustment Counseling Program for Veterans of the Vietnam Era

Readjustment counseling services may now be provided at the request of any veteran who served on active duty during the Vietnam era[14] (August 5, 1964, to May 7, 1975)[15] If a VA physician or psychologist (or, where none is available, a physician or psychologist contracting with the VA), finds that the veteran needs mental health services to readjust to civilian life, such services may be provided.[16] If the veteran requesting readjustment counseling is determined to be ineligible, he or she may be referred to a non-VA facility.[17] Professionals, paraprofessionals, and lay personnel (including volunteers) may be trained to do readjustment counseling.[18] The Chief Medical Director is also authorized to contract with private facilities for the provision of medical services to veterans suffering from total service-connected disabilities.[19]

Treatment and Rehabilitation for Alcohol or Drug Dependence or Abuse Disabilities (Pilot Program)[20]

Recent amendments provide for a pilot program that allows the Administrator "to contract for care and treatment and rehabilitative services in halfway houses, therapeutic communities, psychiatric residential treatment centers, and other community-based treatment facilities of eligible veterans suffering from alcohol or drug dependence or abuse disabilities."[21] This section also provides for information and referral services to those applicants who are found to be ineligible for the program.

Preventive Health Care Service (Pilot Program)

A preventive health care services pilot program[22] has been authorized until September 30, 1984,[23] to ensure the best possible health care for certain veterans with service-connected disabilities and to determine the cost-effectiveness and medical advantages of providing such services.[24] Preventive health care services include: periodic medical and dental examinations; patient health education; maintenance of drug use profiles, patient drug monitoring, and drug utilization education; mental health preventive services; substance abuse preventive measures; immunizations; prevention of musculoskeletal deformity, etc.; genetic counseling; vision testing and eye care services; reexamination of high risk groups for selected diseases, etc.; and such other health care services as the Administrator may determine to be necessary to provide effective and economical health care.

Also of benefit to veterans and the public is the extensive research program of the Veterans Administration, authorized as a means of contributing to knowledge in the field of medicine and surgery.[25] Much of the research is concentrated in the areas of orthopedic surgery and neurology, especially spinal cord injuries.[26]

Eligibility

Title 38 of the U.S. Code, Veterans Benefits, states in the introduction:

> Hospital and nursing home care are available in the VA's 172 hospitals and 16 domiciliaries for (1) any veteran for a service-connected disability or for a non-service-connected disability if he or she is unable to defray the cost of hospital care; (2) a veteran discharged or released for a disability incurred or aggravated in line of duty; (3) a person who is in receipt of, but for the receipt of retirement pay, would be entitled to disability compensation; and (4) any veteran for a non-service-connected disability if such veteran is 65 years of age or older or in receipt of pension.[27]

The Veterans Administration has established a policy on the priorities for hospital and outpatient care. Eligible veterans are to be admitted for hospital care according to priorities in the following order:

(1) Emergency care is given to anyone, regardless of his or her eligibility status if the presenting medical problem is so serious as to endanger life or cause irreparable harm. Those who have a psychotic condition will not be given priority for treatment if they can be transported to another hospital without harm.[28]

(2) Patients who were previously treated in the hospital and remain on the hospital rolls for

[14] 38 U.S.C.A. §612A(Supp. 1979).
[15] *Id.* §1730(k).
[16] *Id.* §612A.
[17] *Id.*
[18] *Id.* §612A(d).
[19] *Id.* §612A(e).
[20] *Id.* §620A.
[21] *Id.* §620A(a)(1).
[22] *Id.* §661.
[23] *Id.* §612(b).
[24] *Id.* §661.
[25] 38 U.S.C. §4101(c)(1)(1976).
[26] Engquist Interview.
[27] 38 U.S.C. introduction at 6.
[28] 38 C.F.R. §17.49(a)(1)(1979).

continuation of treatment, but who do not currently occupy a bed, form the next category.[29]

(3) Priority is given to individuals according to their membership in one of the following 10 groups:[30]

Group I[31]

(a) Veterans requiring hospital treatment for service-connected or adjunct disabilities.

(b) Active duty armed forces personnel who are transferred in anticipation of their retirement or separation from active service.

(c) Veterans in need of vocational rehabilitation under specified conditions.

Group II[32]

(a) Persons who require hospitalization for observation and examination purposes, under specified conditions, at the request of authorized VA officials.

(b) Persons who are eligible for treatment because of service-related disabilities, or non-service-related disabilities that can be said to be aggravating a service-related disability and who are currently in a non-VA hospital.

Group III[33]

(a) Veterans who have been discharged or released from active duty and are receiving hospital care from the Veterans Administration for service-related disabilities and who require treatment for non-service-related disabilities;[34] or who swear under oath that they are unable to pay the cost of needed treatment and who are suffering from chronic or curable disabilities, diseases, or defects;[35] or who have a non-service-connected disability and are 65 years of age or older,[36] and whose transfer to a VA hospital has been requested, except for those who do not have service-related disabilities but require psychiatric care for more than 6 months.

(b) Patients who are suffering from service-related disabilities[37] and who are in VA hospitals that are not the nearest ones to the point of application, if according to clinical estimates transfer to the nearer hospital will require 90 days or more of treatment in that hospital.

(c) Patients who are suffering from service-related disabilities[38] and who are hospitalized in an appropriate VA hospital but who wish to be in a hospital closer to their home and whose treatment will require 90 or more days in the new hospital.

Group IV[39]

Veterans who meet specified eligiblity requirements[40] and who require hospital treatment for non-service-related disabilities and are not in VA hospitals or in non-VA hospitals under VA authorization.

Group V[41]

(a) Veterans who have non-service-related disabilities and who are unable to pay for treatment or are 65 or older[42] and have been admitted to general medical/surgical VA hospitals, and require neuropsychiatric care for more than 6 months in a VA hospital specializing in such care.

(b) Veterans who have non-service-related disabilities and who are unable to pay for treatment or are 65 years or older[43] and who wish to be transferred to a hospital nearest to the point of application, provided that treatment will require 90 or more days in the more appropriate facility.

(c) Veterans who have non-service-related disabilities, are unable to afford treatment or who are 65 years or older[44] and wish to be transferred to a hospital nearer their own home, and at their own expense.

Group VI[45]

Veterans who are unable to pay for the cost of treatment or are 65 years or older[46] and are not hospitalized by the VA.

Group VII[47]

Medical care may be provided for: (1) The spouse or child of a veteran who has a total disability, permanent in nature, resulting from a service-connected disability, and (2) The surviving spouse or child of a veteran who died as a result of a service-connected disability who are not otherwise eligible for medical care as beneficiaries of the

[29] *Id.*
[30] *Id.*
[31] *Id.*
[32] *Id.*
[33] *Id.*
[34] *Id.* §17.47(c), (d) and (f).
[35] *Id.*
[36] *Id.*
[37] *Id.* §17.47(a) and (b).
[38] *Id.*
[39] *Id.* §17.49(a)(3)(iv).
[40] *Id.* §17.47(c).
[41] *Id.* §17.49(v)(a),(b) and (c).
[42] *Id.* §17.47(d) and (f).
[43] *Id.*
[44] *Id.*
[45] *Id.* §17.49(a)(3)(vi).
[46] *Id.* §17.47(d) and (f).
[47] *Id.* §17.49(a)(3)(vii).

Armed Forces under the provisions of Chapter 55 of Title 10, United States Code (CHAMPUS).[48]

Group VIII[49]

Persons on active duty or retired military personnel, beneficiaries from other Federal agencies, veterans of allied nations, the First and Second World Wars, and others as specified.[50]

Group IX[51]

Persons requesting a transfer from one VA hospital to another at their own expense and for their own reasons, provided treatment in the new hospital will be required for a period of 6 months or more.

Group X[52]

Veterans who are unable to pay for treatment or are 65 years or older[53] and who incur an occupational injury or suffer a disease or disability that is related to their employment, and who are covered by employment or disability insurance or could receive treatment elsewhere at no cost to themselves.

(4) Categories within priority groups will be either "urgent" or "general" depending upon the opinion of the examining physician with respect to medical need for hospital care.[54] When a suitable bed is vacant, it will be filled according to priority and the category within a priority.[55] These same principles will apply in non-VA hospitals.[56]

The Veterans Administration also authorizes hospital services to certain dependents of veterans. Those eligible are the spouses and children of veterans who have been totally and permanently disabled as a result of a service-connected disability. Services are also provided for surviving spouses and children of veterans who die as a result of a service-related disability and who are not otherwise eligible for medical care as the beneficiaries of the Armed Forces under the provisions of chapter 55 of Title 10, U.S.C. (CHAMPUS).[57]

[48] *Id.* §17.54(a).
[49] *Id.* §17.46(a)(3)(viii).
[50] *Id.* §17.46(b),(c) and (d).
[51] *Id.* §17.49(a)(3).
[52] *Id.*
[53] *Id.* §17.47(d) and (f).
[54] *Id.* §17.49(a)(4).
[55] *Id.*

Veterans and certain dependents are also eligible for outpatient services in accordance with VA regulations. Briefly summarized, these regulations state that outpatient medical services may be provided to the following applicants:

- For service-connected disability.
- For disability for which discharged.
- For veterans entitled to vocational rehabilitation.
- For Spanish American War veterans.
- For World War I veterans.
- For prehospital care.
- For posthospital care.
- For adjunct treatment.
- For veterans 80 percent or more disabled from a service-connected disability.
- For veterans who are housebound or in need of aid and attendance.[58]

Additional reference to eligibility is made in section 612A, Eligiblity for Readjustment Counseling and Related Mental Health Services.[59] Counseling may be furnished to veterans within the limits of the Veterans Administration to help them readjust to civilian life if such counseling is requested within 2 years after the date of discharge or release from active duty or 2 years after the effective date of this section, whichever is later. Counseling may include general mental and psychological assessments to ascertain whether the veteran has mental or psychological problems associated with readjustment to civilian life. Information and referral services may be provided for those requesting counseling who are not eligible. Those ineligible include veterans who were discharged dishonorably.[60]

Funding

The budget appropriations for the medical services for 1978 through 1980 were: FY 1978, $5,169.1 billion; FY 1979, $5,696.7 billion; and FY 1980, $5,683.7 billion.[61]

[56] *Id.*
[57] *Id.* §17.54(a)(1) and (2).
[58] *Id.* §17.60(a)–(i).
[59] 38 U.S.C.A. §612A (Supp. 1979).
[60] *Id.*
[61] Jack McDonnel, staff member, Subcommittee on Veterans Affairs, U.S. House of Representatives, interview, Nov. 30, 1979.

Community Mental Health Centers

The authority for the establishment and operation of federally supported community mental health centers (CMHCs) is provided by the Community Mental Health Centers Act of 1963,[1] as amended.[2] CMHCs are public or private nonprofit agencies or organizations organized to provide comprehensive mental health services to the residents of a defined mental health service area usually comprised of 75,000 to 200,000 people.[3] The Secretary of Health and Human Services is authorized to make grants to qualifying agencies for the planning and operation of CMHCs.[4] Approximately 788 CMHCs have been funded to provide the full range of essential mental health services under various provisions of the act.[5]

Organization

The program for community mental health centers is administered at the Federal level by the National Institute of Mental Health (NIMH), in the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA), Public Health Service, Department of Health and Human Services. Overall direction of the program is provided from NIMH headquarters in Rockville, Maryland. The supervision of State plans for mental health services and the administration of CMHC grants is done by the ADAMHA divisions in the 10 Federal regional offices of DHHS. Funds are authorized for the provision of Federal technical assistance and training to assist in providing improved management of CMHCs.[6]

The State-designated mental health agency is responsible for the development of an overall plan for mental health services.[7] To be eligible for the receipt of a CMHC grant, an applicant must have its prospective program included in the State plan[8] for mental health services. At the same time an application for a CMHC grant is submitted to DHHS, it must also be submitted to the State mental health agency for its review and recommendations.[9] Applications for CMHC grants must be approved also by the National Advisory Mental Health Council.[10]

Community mental health centers are organized to provide a full range of mental health services to the residents of the defined geographic area. A CMHC may either be a public or a private nonprofit agency. The governing board must be composed of individuals who reside in the catchment area.[11] Where the CMHC is operated by a governmental agency or a hospital, it may establish an advisory committee composed of residents of the catchment area in lieu of a governing board.[12]

Benefits

Federal Assistance

Federal assistance to CMHCs is provided through several types of grants:

Planning Grants[13]

Grants of no more than $75,000 may be awarded to public or private nonprofit organizations to plan a program of community mental health services. Grants are for a period of 1 year and are not renewable. Priority is given to the planning of urban or rural CMHCs that will serve poverty areas. Applications for all CMHC grants in FY 81 must be approved by the National Advisory Mental Health Council.

Initial Operation Grants[14]

Grants may be made to a CMHC to assist it in meeting its initial operating costs, covering those that will not be met by State or local funding or by the payments by clients for services. Operation grants may be provided to a CMHC for a maximum period of 8 years, on a percentage or deficit basis, whichever is less.[15] Over the 8-year period the level of Federal participation for nonpoverty areas is as follows:

[1] Pub. L. No. 88-164, 77 Stat. 282 (codified as amended at 42 U.S.C.A. §§2689-2689aa (Supp 1979).
[2] Pub. L. No. 94-63, 89 Stat. 309; Pub. L. No. 95-622, 92 Stat. 3414; 42 U.S.C.A. §2689.
[3] 42 U.S.C.A. §2689(a)(1)(A)(Supp. 1979); 42 C.F.R. Part 54. 104(b) (1979).
[4] 42 U.S.C.A. §§2689a-2689i(Supp. 1979).
[5] Frances Premo, program analyst, Operations Branch, NIMH, telephone interview, Washington, D.C., Dec. 7, 1979.
[6] 42 U.S.C.A. §2689e(e)(1)(Supp. 1979).
[7] *Id.* §2689t.
[8] *Id.* §2689e(a)(1).
[9] *Id.* §2689e(d).
[10] *Id.* §2689e(c)(2)(C).
[11] *Id.* §2689(c)(1)(A).
[12] *Id.* §2689(c)(1)(B).
[13] *Id.* §2689a.
[14] *Id.* §2689b.
[15] *Id.* §2689b(a)(2).

(1) Year One: 80 percent;
(2) Year Two: 65 percent;
(3) Year Three: 50 percent;
(4) Year Four: 35 percent;
(5) Years Five and Six: 30 percent; and
(6) Years Seven and Eight: 25 percent.[16]

If the CMHC operates in a designated rural or urban poverty area, these percentages are:

(1) Years One and Two: 90 percent;
(2) Year Three: 80 percent;
(3) Year Four: 70 percent;
(4) Year Five: 60 percent;
(5) Year Six: 50 percent;
(6) Year Seven: 40 percent; and
(7) Year Eight: 30 percent.[17]

Grants for Consultation and Education Services[18]

A grant may be made to a CMHC for costs of consultation and education services. These may include a range of activities designed to develop effective mental health programs, promote greater coordination of the provision of mental health services, increase the community's awareness of the nature of mental health problems and the types of services available, and promote the prevention and control of rape and the proper treatment of rape victims.[19] Consultation and education grants may cover the full costs of providing such services or be based on a formula that considers the population of the catchment area.[20] The amount of the annual grants may not exceed the lesser of 100 percent of the center's consultation and education costs or the formula stipulation in the law.

Financial Distress Grants[21]

These grants may be made to a funded CMHC to assist in its operating costs where it can be shown that without the grant there would be a significant reduction of the services provided or an inability to provide any of the required essential mental health services. To be eligible a center must have exhausted its eligibility to receive a staffing or an initial operations grant, submit to a thorough audit of its records, and implement recommmendations for reform indicated by cost analysis study.[22] Grants are made for a period of 1 year, and no CMHC may receive more than 5 grants.[23]

Facilities Assistance[24]

Although there are no current funds authorized, these grants were made to CMHCs to assist in covering the costs of:

(1) acquiring and/or remodeling a facility for use as a CMHC;
(2) leasing a facility for use as a CMHC (for a period of more than 25 years);
(3) constructing a new CMHC facility or expanding an existing facility if no less than 25 percent of the residents of the catchment area are members of a low-income group; and
(4) purchasing the initial equipment for an acquired, remodeled, leased, constructed, or expanded facility. Payments cannot be made for new construction without a showing that it was not feasible to acquire or remodel an existing building. The Federal share for any project could not exceed 66-2/3 percent of the costs.[25] For CMHCs serving designated poverty areas the maximum Federal share of the costs for a facilities assistance project is 90 percent.[26]

Client Benefits

CMHCs provide comprehensive mental health services primarily to the residents of their catchment areas. During the first 3 years of the CMHCs' operations, it must provide the following "essential services":[27]

- Inpatient services.
- Emergency services.
- Outpatient services.
- Screening services for courts and other public agencies considering the referral of persons to State mental health facilities, to determine if the referral is appropriate; where appropriate, the provision of treatment as an alternative to inpatient care in a State mental health facility.
- Followup care for persons discharged from inpatient care at a mental health facility.
- Consultation and education services, which are for a wide range of individuals, agencies, and organizations involved with mental health services

[16] *Id.* §2689b(c)(2)(A).
[17] *Id.* §2689b(c)(2)(B).
[18] *Id.* §2689c.
[19] *Id.* §2689(b)(1)(A)(iv)(II).
[20] *Id.* §2689c(b).
[21] *Id.* §2689f(2).
[22] *Id.* §2689g(a).
[23] *Id.* §2689g(c).
[24] *Id.* §2689i(a).
[25] *Id.* §2689i(b)(2).
[26] *Id.* §2689i(b)(3).
[27] *Id.* §2689(b)(1)(A).

and include a range of activities to develop effective mental health programs, promote greater coordination of the provision of mental services, increase the community's awareness of the nature of mental health problems and the types of services available, and promote the prevention and control of rape and proper treatment of rape victims.

At some point during the first 3 years, but no later than the end of the third year, a CMHC must also provide the following services:[30]

- Day care and other partial hospitalization services.
- Specialized services for the mental health of children, including a full range of diagnostic, treatment, liasion, and followup services.
- Specialized services for the elderly, including a full range of diagnostic, treatment, liasion, and followup services.
- Transitional services such as halfway houses for mentally ill persons returning to the community from an inpatient mental health facility or who would require inpatient care in such a facility in the absence of the alternative forms of care.
- Where there is a need in the catchment area, programs for the prevention and treatment of drug addiction and abuse and for rehabilitation of drug addicts and drug abusers, and other persons with dependency-related problems.
- Where there is a need in the catchment area, programs for the prevention and treatment of alcoholism and alcohol abuse,

and for the rehabilitation of alcoholics and alcohol abusers.

Eligibility

Community Mental Health Centers

To be eligible to receive a Federal grant a CMHC must meet the following requirements:

(1) Must be a public or private nonprofit agency or organization;[29]

(2) Have a governing board (private nonprofit agencies) or an advisory committee (public agencies and hospitals) composed of residents of the catchment area,[30]

(3) Must serve a defined service area and consult with the residents of the area to assure that its services are responsive to the residents' needs, including the needs of persons who do not speak English as their primary language;[31]

(4) To the extent practicable, have cooperative arrangments with health maintenance organizations serving the same area;[32]

(5) Have requirements and procedures for professional supervision of medical services;[33]

(6) Have a plan for ongoing financial support of the facility so that it can continue to provide comprehensive mental health services after such time as the Federal assistance is terminated, including procedures for the collection of client fees on a sliding scale;[34] and

(7) Must provide all the comprehensive mental health services prescribed by the Federal legislation.[35]

Individuals

Any individual residing in the defined service area is eligible to receive all CMHC services, as required.

Funding

The funding levels for the various elements of the CMHC program are as follows:

1. Planning Grants

The CMHC legislation authorized $1.5 million for planning grants in fiscal year 1979 and $1.0 million for fiscal year 1980.[36] No appropriation was made for planning grants in fiscal year 1979, however, and no funds were requested for fiscal year 1980.[37]

2. Initial Operations Grants

Some $34.5 million was authorized for expenditure as initial operations grants in fiscal year 1979 and $35 million for fiscal year 1980 and $37 million for fiscal year 1981.[38] In fiscal year 1979 an estimated $30.5 million was obligated for initial operation

[29] *Id.* §2689(b)(1)(B).
[30] *Id.* §2689a(a).
[30] *Id.* §2689(c).
[31] *Id.* §2689e(c)(1) (B) and (D).
[32] *Id.* §2689(c)(1)(C).
[33] *Id.* §2689e(c)(1)(E) and (F).
[34] *Id.* §2689e(c)(1)(H).
[35] *Id.* §2689(b)(a)(1).
[36] *Id.* §2689a(b).

[37] U.S., Department of Health, Education, and Welfare, Office of the Secretary for Health, *Fiscal Year 1980 Justification of Appropriation Estimates for Committee on Appropriations*, vol. IV., p. 11 (hereafer cited as *Appropriations Justifications).*
[38] 42 U.S.C.A. §2689b(d)(1)(Supp. 1979) for FY 79 figure. The FY 80 figure was provided by Dr. Richard Cravens, Community Mental Health Centers Division, ADAMHA, DHHS (hereafter cited as Cravens Interview).

grants, making a total outstanding of $203.8 million in obligations.[39]

3. Consultation and Education Grants

Expenditure of $20 million was authorized for consultation and education grants in fiscal year 1979 and $3 million in fiscal year 1980 and $15 million in FY 81.[40] An estimated $9.2 million was expended for consultation and education grants in fiscal year 1979 and $3.3 million in 1980.[41]

4. Conversion Grants

The authorization for conversion grants was $30.0 million for fiscal year 1979 and $25.0 million for fiscal year 1980.[42] Approximately $10.8 million was expended in fiscal year 1979, and $1.1 million in 1980.[43]

5. Financial Distress Grants

Some $25 million was authorized for financial distress grants in fiscal year 1979, with no authorization for fiscal year 1980 and $20 million for FY 81.[44] Approximately $12 million was expended for financial distress grants in fiscal year 1979.[45] For fiscal year 1980, approximately $5.4 million was expended.[46]

6. Facilities Assistance Grants

The legislative authorization for facilities assistance grants expired at the end of fiscal year 1978.[47]

[39] *Appropriations Justification*, p. 11 for FY 79 figure and Dr. Cravens for the total obligation.
[40] 42 U.S.C.A. §2689c(c)(Supp. 1979). For the FY 79 and FY 80 figures and Dr. Cravens for the FY 81 figure.
[41] *Appropriations Justification*, p. 11.
[42] 42 U.S.C.A. §2689d(c)(Supp. 1979).
[43] Cravens interview.
[44] 42 U.S.C.A. §2689h (Supp. 1979) for FY 79 and FY 80 figures; Cravens interview for FY 81.
[45] *Appropriations Justification*, p. 11.
[46] Cravens interview.
[47] 42 U.S.C.A. §2689p (Supp. 1979).

Alcholism Prevention, Treatment, and Rehabilitation

In 1970 Congress passed the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act establishing the National Institute on Alcohol Abuse and Alcoholism (NIAAA).[1] This act, as amended,[2] authorizes the NIAAA to develop and conduct comprehensive health, education, training, research, and planning programs for the prevention and treatment of alcohol abuse and alcoholism.[3]

Among the provisions of the act, as amended, are the following:

(1) A program of formula grants to the States to assist them in planning, establishing, maintaining, coordinating, and evaluating projects for the development of more effective prevention, treatment, and rehabilitation programs to deal with alcohol abuse and alcoholism.[4]

(2) Project grants to public and nonprofit entities and contracts to public and private entities and individuals for the prevention and treatment of alcohol abusers and alcoholics.[5]

(3) Special grants to assist States with the implementation of the Uniform Alcoholism and Intoxication Treatment Act.[6]

(4) A program of research grants and contracts for the purpose of interdisciplinary research relating to alcoholism and other alcohol problems.[7]

Organizational Structure

The 1974 amendments to the Comprehensive Alcohol Abuse and Alcohol Prevention, Treatment, and Rehabilitation Act of 1970 established the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) in the former Department of Health, Education, and Welfare (HEW).[8] ADAMHA is now located in the Department of Health and Human Services. This administration houses three institutes: the National Institute on Drug Abuse (NIDA), the National Institute on Mental Health (NIMH), and the National Institute on Alcohol Abuse and Alcoholism.[9]

NIAAA is administered by a Director.[10] The National Advisory Council on Alcohol Abuse and Alcoholism acts as an advisor to the administration[11] and has authority over policies and priorities for research grants and contracts.[12]

NIAAA is authorized to approve alcohol abuse and alcoholism programs from a comprehensive perspective of community care[13] through Federal, State, and local planning.

Federal Level

At the Federal level, NIAAA administers and plans for project grants and contracts to local communities,[14] administers State formula grants[15] and special State incentive grants,[16] and administers a program of research.[17] The 1974 amendments also established the Interagency Committee on Federal Activities for Alcohol Abuse and Alcoholism.[18] This committee evaluates the adequacy and technical soundess of all Federal programs and activities that

[1] Pub. L. No. 91-616, 84 Stat. 1848 (1970)(codified as amended at 42 U.S.C.A. §§4541-4593)(1977 and Supp. 1979)(as amended by Pub. L. No. 90-180, 93 Stat. 1301)(1980);(see in particular 42 U.S.C.A. §4551 (1977 and Supp. 1979).

[2] The act has subsequently been amended on five occasions by acts entitled The Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act Amendments of 1974, 1976, 1977, 1978, and 1979, respectively. (Hereafter 1974 Amendments, etc.) 1974 Amendments, Pub. L. No. 93-282, 88 Stat. 135; 1976 Amendments, Pub. L. No. 94-371, 90 Stat. 1035; 1977 Amendments, Pub. L. No. 95-83, 91 Stat. 397; 1978 Amendments, Pub. L. No. 95-622, 92 Stat. 3457; 1979 Amendments, Pub. L. No. 96-180, 93 Stat. 1301.

[3] 42 U.S.C.A. §4551 (1977).

[4] 42 U.S.C.A. §§4571-4573 (1977 and Supp. 1979)(as amended by Pub. L. No. 96-180, §§7-9, 93 Stat. 1303 (1980)).

[5] 42 U.S.C.A. §4577 (1977 and Supp. 1979)(as amended by Pub. L. No. 96-180, §11, 93 Stat. 1304 (1980).

[6] 42 U.S.C.A. §4576 (1976)(as amended by Pub. L. No. 96-180, §10, 93 Stat. 1304 (1980)).

[7] 42 U.S.C.A. §4585 (1977 and Supp. 1979).

[8] 42 U.S.C. §3511(a)(1976).

[9] *Id.* 3511(b).

[10] 42 U.S.C. §4551(b)(1976).

[11] 42 U.S.C.A. §218(d)(Supp. 1978).

[12] 42 U.S.C.A. §4577(c)(2)(B)(1977 and Supp. 1979) (as amended by Pub. L. No. 96-180, §11, 93 Stat. 1304 (1980)).

[13] 42 U.S.C. §4541(b)(1)(1976).

[14] 42 U.S.C.A. §4577 (1977 and Supp. 1979)(as amended by Pub. L. No. 96-180, §11, 93 Stat. 1304 (1980)).

[15] 42 U.S.C.A. §§4571-73 (1977 and Supp. 1979) (as amended by Pub. L. No. 96-180, §§8-9, 93 Stat. 1303 (1980)).

[16] 42 U.S.C. §4576(1976)(as amended by Pub. L. No. 96-180, §10, 93 Stat. 1304 (1980)).

[17] 42 U.S.C.A. §§4585-88 (1977 and Supp. 1979)(as amended by Pub. L. No. 96-180, §§14-16, 93 Stat. 1304 (1980)).

[18] 42 U.S.C. §§4553(1976)(as amended by Pub. L. No. 96-180, §5 93 Stat. 1302 (1980)).

relate to alcoholism and alcohol abuse and maintains the coordination of such programs.[19] The committee includes members from those Federal agencies with programs directly affecting alcoholism and alcohol abuse.[20]

State Level

Each State must designate a single State agency as the sole agency for the administration of the alcoholism plan.[21] A State advisory council consults with the State agency in carrying out the plan.[22] A State prevention coordinator initiates public awareness information on the effect of alcohol abuse and alcoholism.[23]

Local Level

At the local level, grants and contracts can be funded either directly from the Federal grants and contracts program or through formula grant monies available to the States. Grantees represent a wide range of public and nonprofit agencies such as mental health centers, hospitals, community action agencies, charitable organizations, and county governments.[24]

Whenever possible, prevention and treatment grants and contracts are to be community based and integrated with other community services. The State agency must assure, in the State plan, that it will coordinate its planning with local alcoholism and alcohol abuse planning agencies and with other local health planning agencies.[25]

Benefits

Benefits are provided to State and local programs through three major funding mechanisms:

- Formula grants to States;[26]
- Project grants to public and nonprofit private entities,[27] (including State incentive grants for implementation of the Uniform Alcoholism and Treatment Act);[28]
- Direct grants for research.[29]

Major benefits provided through these funding mechanisms include programs for prevention, treatment, rehabilitation, training, and research.

Prevention

NIAAA oversees the developing, testing, and evaluation of practical methods of preventing the abuse and misuse of alcoholic beverages.[30] Each of the 48 participating States and territories has a prevention coordinator who works in public education campaigns, initiates public discussions with local communities, assists youth and adult groups in surveys of drinking patterns, and develops prevention advocacy groups.[31] The demonstration grant program affords the opportunity for local communities to organize, study, and implement creative prevention approaches to modify harmful drinking practices within the community.[32] The National Clearinghouse for Alcohol Information acts as an information service for NIAAA.[33]

Treatment

NIAAA's Operation Mainstream attempts to bring the treatment of alcoholism into the mainstream of the Nation's health-care delivery system.[34] Occupational programs have been developed at the State and local level to help employees whose job performance has become impaired because of alcohol abuse and alcoholism.[35] Assistance has been provided to communities to develop direct delivery services (e.g., counseling, treatment, referrals) for alcoholics[36] Studies also are done to analyze a broad range of issues in order to improve service delivery at the community level.[37]

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[19] *Id.*
[20] *Id.*
[21] 42 U.S.C. §4573(a)(1)(1976).
[22] 42 U.S.C. 4573(a)(3) (1976) (as amended by Pub. L. No. 96-180, §9, 93 Stat. 1303 (1980)).
[23] U.S., Department of Health, Education, and Welfare, National Clearinghouse for Alcohol Information, "The National Institute on Alcohol Abuse and Alcoholism," no. PH 84, 1977, unpaginated (hereafter cited as *NIAAA).*
[24] Bill Gregory, chief, Eastern Section, Special Project Grants, NIAAA, telephone interview, Dec. 13, 1979 (hereafter referred to as Gregory Interview).
[25] 42 U.S.C. §4573(a)(12)(1976)(as amended by Pub. L. No. 96-180, §9(a)(4), 93 Stat. 1303 (1980)).
[26] 42 U.S.C.A. §§4571-4573 (1977 and Supp. 1979)(as amended by Pub. L. No. 96-180, §§7-9, 93 Stat. 1303 (1980)).
[27] 42 U.S.C.A. §4577 (1977 and Supp. 1979)(as amended by Pub. L. 96-180, §11, 93 Stat. 1304 (1980)).
[28] 42 U.S.C. §4576 (1976) (as amended by Pub. L. No. 96-180, §10, 93 Stat. 1304 (1980)).
[29] 42 U.S.C.A. §4585 (1977 and Supp. 1979) (as amended by Pub. L. No. 96-180, §14, 93 Stat. 1305 (1980)).
[30] *NIAAA.*
[31] Ibid.
[32] Ibid.
[33] Ibid.
[34] Ibid.
[35] Ibid.
[36] Ibid.
[37] Ibid.

Education and Training

Under the legislative mandate for manpower development, NIAAA established the National Center for Alcohol Education in May 1973.[38] The center's primary goal is to improve the effectiveness of alcohol-related services through the development of model training programs, which can be widely used by practitioners in the field and by the development of educational materials for the general public.[39] NIAAA is also working on credentialing of alcoholism personnel, degreed and nondegreed.[40]

Research

A special authorization was included in the 1976 amendments to the act for research and support of national alcohol research centers.[41] The Division of Intramural Research collaborates with agencies, universities, and scientific organizations to conduct basic and clinical research on alcohol and its effect.[42] Extramural research includes support for basic and applied research into the causes and treatment of alcoholism, particularly in the areas of clinical research, prevention and education, behavioral and psychological studies, and the psychological effects of alcohol.[43]

Eligibility

Individuals with alcohol abuse or alcoholism problems and their families are eligible for services through the various programs funded through NIAAA.[44] With regard to confidentiality of records, the act, as amended, and implementing regulations restrict the disclosure and use of information concerning clients of all federally assisted programs that provide diagnosis and treatment or referral of alcohol abuse clients.[45] Disclosure without specific written consent is authorized only in the specific cases described in Federal confidentiality regulations, such as for research, audit, or evaluation purposes and in a medical emergency.[46]

Formula Grants

Formula grant funds are allotted to States on the basis of the relative population, financial need, and the need for more effective prevention, treatment, and rehabilitation programs.[47] To qualify for funds, the State agency must have an approved State plan that is reviewed and updated annually.[48] A State advisory council consults with the State agency in carrying out the plan.[49]

The State must designate a single State agency as sole administrator of the plan or sole supervisor of administration of the plan;[50] provide for a State advisory council to include, among others, representatives of the statewide health coordinating council and public agencies concerned with prevention, treatment, and rehabilitation of alcoholic abuse and alcoholism;[51] inventory all public and private resources available in the State for alcohol abuse and alcoholism treatment, prevention, and rehabilitation;[52] and assure that the State agency will coordinate the planning with other State and local health planning agencies.[53]

Project Grants and Contracts

Public and nonprofit private entities are eligible for grants, and public and private entities and individuals are eligible for contracts, for the prevention and treatment of alcohol abuse and alcoholism.[54] The projects submitted under this program must be approved by the State agency[55] and meet the criteria established by the Secretary of Health and Human Services.[56] Whenever possible, these projects are community based and provide a comprehensive range of services (e.g., treatment, public information, referral, etc.) that are integrated with and involve the active participation of a wide range of public and nongovernmental agencies, organizations, institutions, and individuals. Where a substantial number of individuals in the population served

[38] Ibid.
[39] Ibid.
[40] Ibid.
[41] 1976 Amendments, Pub. L. No. 94-371, §7, 90 Stat. 1038 (codified as amended at 42 U.S.C.A. §§4585, 4588 (1977 and Supp. 1979) (as amended by Pub. L. No. 96-180, §§14, 16, 93 Stat. 1305 (1980)).
[42] *NIAAA.*
[43] Ibid.
[44] Gregory Interview.
[45] 42 U.S.C. §4582 (1976); 42 C.F.R. Part 2 (1979).
[46] *Id.*
[47] 42 U.S.C.A. §4572(a)(Supp. 1979).
[48] 42 U.S.C. §4573(a)(8)(1976).
[49] 42 U.S.C. §4573(a)(3)(1976)(as amended by Pub. L. No. 96-180, §9(a) (1), 93 Stat. 1303 1980)).
[50] *Id.* §4573(a)(1).
[51] 42 U.S.C. §4573(a)(3)(1976)(as amended by Pub. L. No. 96-180, §9(a)(1), 93 Stat. 1303 (1980)).
[52] *Id.* §4573(a)(11).
[53] 42 U.S.C. §4573(a)(12)(1976)(as amended by Pub. L. No. 96-180, §9(a)(4), 93 Stat. 1303 (1980)).
[54] 42 U.S.C. §4577(a)(1976)(as amended by Pub. L. No. 96-180, §11, 93 Stat. 1304 (1980)).
[55] *Id.* §4577(c)(2)(A).
[56] *Id.* §4577(c)(3).

by the project is of limited English-speaking ability, provisions are to be made to respond to their needs.[57]

The community-based grants and contracts provide treatment and prevention services with special emphasis on currently underserved populations.[58] Education and training services are also available through this program.[59] The Secretary is to give special consideration to applications for programs and projects for the prevention and treatment of alcohol abuse and alcoholism by women and individuals under the age of 18.[60]

Special Grants to States

To participate in the special grants to States program for implementation of the Uniform Alcoholism and Intoxication Act,[61] the State must submit an application which indicates that:(1) the State and political subdivisions are committed to the concept of care of alcohol abuse through community health and social services;[62] (2) those portions of criminal statutes under which drunkenness is the graveman of a petty criminal offense (e.g., loitering, vagrancy, disturbing the peace) have been repealed;[63] and (3) State laws regarding the acceptance of individuals into treatment programs are in accordance with the following standards: (a) voluntary treatment is perferred over involuntary treatment, (b) outpatient or intermediate treatment is preferred over inpatient treatment, (c) an individual cannot be denied treatment solely because of previous withdrawal from treatment or relapse, and (d) current individual treatment plans are maintained for each patient.[64]

Research Grants

Research grants are available directly and through grants and contracts to universities, hospitals, laboratories, and other public and nonprofit institutions and to individuals for such research projects as are recommended by the National Advisory Council on Alcoholic Abuse and Alcoholism.[65]

Funding

The appropriations for FY 1979 for NIAAA were approximately $56.8 million for State formula grants; [66] $78.7 million for community programs grants and contracts (536 projects);[67] and $22.2 million for research (175 research grants and projects).[68]

[57] 42 U.S.C. §4577(b)(1)(1976)(as amended by Pub. L. No. 96-180, §11(b), 93 Stat. 1304 (1980)).
[58] 42 U.S.C. §4577(a)(3)(1976)(as amended by Pub. L. No. 96-180, §11(a)(4),93 Stat. 1304 (1980)).
[59] 42 U.S.C. §4577(a)(4)(1976)(as amended by Pub. L. No. 96-180, §11(a)(1), 93 Stat. 1304 (1980)).
[60] 42 U.S.C. §4577(b)(4)(1976)(as amended by Pub. L. No. 96-180, §11(c), 93 Stat. 1304 (1980)).
[61] The Uniform Alcoholism and Intoxification Act is one of a series of laws drafted and recommended by the National Conference of Commissioners on Uniform State Laws. See Senate Committee on Labor and Public Welfare, Report on the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1974. S. Rep. 208, 93rd Cong., 2d Sess. reprinted in 1974, 2 U.S. Code Cong. & Ad. News 3039, 3050.
[62] 42 U.S.C. §4576(b)(1)(1976).
[63] *Id.*
[64] *Id.* §4576(b)(2).
[65] 42 U.S.C. §4585(b)(7)(1976)(as amended by Pub. L. 96-180, §14(b)(1) 93 Stat. 1305 (1980).
[66] Steven Long, Budget Office, NIAAA, telephone interview, Dec. 11, 1979.
[67] Ibid. $10 million of this went to the Uniform Act grants program.
[68] Ibid. $6 million of this went to the national research centers.

Drug Abuse Prevention and Treatment

Overview

In enacting the Drug Abuse Office and Treatment Act of 1972,[1] which established the National Institute of Drug Abuse and its Advisory Councils, Congress sought to address the rapidly increasing abuse of drugs in the United States. Finding first that the extent and impact of drug abuse, especially heroin addiction, to be rapidly increasing and substantially contributing to crime, Congress stated that increased drug abuse constitutes a serious and continuing threat to national health and welfare, requiring immediate and effective response on the part of the Federal Government.[2]

The purpose of the act is to focus the comprehensive resources of the Federal Government on significantly reducing the incidence, as well as the social and personal costs, of drug abuse in the United States, through a comprehensive, coordinated, long-term national strategy to combat drug abuse.[3] To accomplish these goals, the act emphasizes efforts to meet the needs of special populations, community-based prevention programs, occupational prevention and treatment programs, and increased Federal research into the behavioral and biomedical causes of drug abuse.[4]

A single, Presidentially-designated officer in the Executive Office of the President is responsible for directing a system to develop policies, establish priorities, and coordinate drug abuse functions performed by Federal departments and agencies.[5] To assist in the development of a national drug abuse strategy for all drug abuse prevention functions, the act directs the President to establish a separate Strategy Council in the Executive Office of the President.[6] Finally, the act establishes a National Institute on Drug Abuse (NIDA), within the Department of Health and Human Services (DHHS), to administer the programs and authority of the Secretary of DHHS related to drug abuse prevention, research, treatment, and rehabilitation.[7]

Currently, 70 percent of the drug abuse treatment and prevention activities funded by the Federal Government are administered by NIDA.[8] Through NIDA's grant program, funds are available to the 50 States, territories, and District of Columbia for the establishment of drug abuse prevention and treatment programs.[9] In addition, NIDA offers technical assistance and training to States and local governments to further their drug abuse prevention and treatment objectives. This paper focuses on the NIDA programs.

Organizational Structure

The National Institute for Drug Abuse is a part of the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA).[10] ADAMHA is under the authority of the Public Health Service within the Department of Health and Human Services. ADAHMA maintains drug abuse consultants in DHHS' 10 regional offices to provide technical assistance and consultation to the designated single State agencies for drug abuse.

In the programs authorized by the National Drug Office and Treatment Act of 1972 and its subsequent amendments,[11] State participation is essential. NIDA relies heavily on the States in planning and implementing drug abuse programs nationwide. "The primary mechanism through which treatment services (in the States) have been funded is the Statewide Services Contract (SWSC). The SWSC is a cost-sharing contract, negotiated with designated Single State Agencies, through which local drug treatment programs are subcontracted."[12] NIDA is currently completing the process of converting from contracts to grants with the hope that the grant

[1] Pub. L. No. 92-255, 86 Stat. 65 (1972) (Codified at 21 U.S.C. §§1101-1191 (1976) and scattered sections of Title 42 and Title 5).
[2] 21 U.S.C.A. §1101(9)(1972).
[3] *Id.* §1102 (Supp. 1980).
[4] *Id.*
[5] *Id.* §1111-1114.
[6] *Id.* §1162.
[7] *Id.* §1191.
[8] U.S., Department of Health, Education, and Welfare, National Institute for Drug Abuse, "A Report to the President and the Congress on the Drug Abuse Prevention and Treatment Functions of the Department of Health, Education and Welfare, Fiscal Year 1978" (July 1979), p. iii (hereafter cited as NIDA Annual Report).
[9] Ibid.
[10] 42 U.S.C. §3511 (1976).
[11] (Codified as amended at 21 U.S.C.A. §§1101-1194 (1972 and Supp. 1980) and scattered sections of Title 5 and 42.)
[12] NIDA Annual Report, p. 10.

mechanism will allow the States greater fiscal flexibility.[13] States also receive funds through formula grants that are based on population and need.[14] Both the SWSCs and the formula grants are made to the designated single State agencies. Formula grants are supplementary to the statewide service grants.[15]

Local participation also is a fundamental component of the NIDA program. Local communities are encouraged to participate in the single State agency planning and grants process both as members of the State policymaking advisory commitee and as service providers. Local planning for programs is encouraged to reflect the multiplicity of client needs. The current community-based network of drug abuse treatment services provided care to over 235,000 persons in 1978, through an extensive variety of treatment modalities.[16]

Two advisory councils serve important policymaking roles in the national drug abuse prevention program. They are the National Advisory Council for Drug Abuse Prevention[17] and the President's Strategy Council.[18] The National Advisory Council's function is to assist the Secretary of HHS in the field of drug abuse by advising and making recommendations in such areas as priorities and program development, grant and contract awards, and administration of drug abuse programs.[19] The Strategy Council is mandated among other things, to develop ". . .a comprehensive Federal plan with respect to both drug abuse prevention functions and drug traffic prevention functions, which shall specify the objectives of the Federal strategy and how all available resources, funds, programs, services, and facilities authorized under relevant Federal law should be used. . ."[20]

Single State agencies must also have State advisory councils whose members represent the public and private sectors, as well as different geographical areas and population groups (including women and the elderly) within the State.[21] The State advisory groups fulfill, on the State level, functions similar to those of the Federal-level councils.

Benefits

The benefits of the legislation enacted in behalf of drug abuse treatment and prevention accrue directly and indirectly to the following population and organizations:

• *Drug dependent persons* who require treatment benefit from programs sponsored by community mental health centers[22] and through programs supported by special project grants and contracts[23] to local community-based programs. Special consideration in awarding special grants and contracts is to be given to preventing and treating drug abuse and drug dependence by women, the elderly, and individuals under the age of 18.[24] High priority is to be accorded applications for primary prevention programs, which includes discouraging persons from beginning drug abuse,[25] and special efforts are to be made by grantees and contractors to be responsive to the needs of the handicapped and non-English-speaking populations.[26] Local programming is expected to offer various types of treatment methods in settings that include outpatient, residential, and day care services.[27]

Drug dependent persons who require medical treatment may not be discriminated against in any federally-supported public or private general hospital.[28] The research sponsored by NIDA is focused on the creation, location, development, and testing of nonaddictive and less addictive synthetic analgesics, antidepressents, and other drugs and detoxification agents aimed at easing the physical distress of persons undergoing withdrawal from heroin addiction.[29]

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[13] Ibid.
[14] 21 U.S.C.A. §1176(c)(1)(A)(1972 and Supp. 1980).
[15] Fred Norton, Office of Program Support, NIDA, telephone interview, Rockville, Md., Dec. 11, 1979 (hereafter cited as Norton Interview).
[16] Strategy Council on Drug Abuse, "Federal Strategy for Drug Abuse and Drug Traffic Prevention" at 23 (1979) (hereafter Federal Strategy Paper).
[17] 42 U.S.C. §218(e) (1976).
[18] 21 U.S.C.A. §1161 (Supp. 1980).
[19] 42 U.S.C. §218(e)(2) (1976).
[20] 21 U.S.C. §1163(2) (1976).
[21] 21 U.S.C.A. §1176(e)(3) (Supp. 1980).
[22] 42 U.S.C.A. §2689(b)(B)(v)(II) (Supp. 1980) requires all community mental health centers to provide a program for the prevention and treatment of drug addiction and abuse and/or the rehabilitation of drug addicts, drug abusers and other persons with drug dependency problems within three years of any center's establishment.
[23] 21 U.S.C.A. §1177(a) (1972 and Supp. 1980).
[24] *Id.* §1172(d) (Supp. 1980).
[25] *Id.* §1177(a).
[26] *Id.* §1177(f).
[27] Norton Interview.
[28] 21 U.S.C.A. §1174(a) (Supp. 1980).
[29] *Id.* §1193.

• *Local program developers* may receive financial aid through grants made available through their States' participation in the NIDA special grants program[30] and through their involvement with community mental health center programs.[31]

• *States* may receive funds for the purpose of developing and carrying out comprehensive drug abuse treatment and prevention programs.[32] Technical assistance is available to State and local agencies for analyzing and identifying State and local drug abuse problems, for program planning and development, and for drafting model legislation.[33] State officials and staff and local program staff are also eligible to participate in training programs authorized under drug abuse legislation and sponsored by NIDA.[34]

• *The general public* is another prime beneficiary of NIDA programs. Publicity about drug abuse treatment and prevention programs and materials developed and disseminated through the Drug Abuse Clearinghouse[35] are aimed in part at public education. "In general, drug abuse prevention activities are focused on those individuals who have not yet initiated illicit drug use or for whom drug use has not yet produced serious problems.[36]

Grant Benefits

Benefits are provided to State and local programs through the two major grant programs mentioned above, and detailed further under "Eligibility" below: Special project grants and State Service contracts grants[37] and formula grants.[38] The major benefits provided through these funding mechanisms may be categorized as programs for prevention, treatment, research, and training.[39]

Prevention

The prevention of drug abuse is one of NIDA's primary program functions and is being addressed through the provision of information, education, program alternatives, and direct intervention.[40]

NIDA also operates a national clearinghouse for the collection, preparation, and dissemination of information and educational materials related to drug abuse prevention. Information and educational materials are disseminated directly to the public and through the single State agencies. The single State agencies serve an important prevention role since they are charged with planning, coordinating, and administering State drug abuse prevention and treatment programs.[41] Programs are encouraged to include alternative and intervention programs for children and youth[42] aimed at enhancing their self-confidence, self-discipline, and awareness.

Treatment

Treatment is fundamental to the NIDA mandate.[43] Individuals and their families who face any form of drug addiction may be the beneficiaries of a variety of community-based drug prevention, treatment, and rehabilitation programs. Treatment is also made available to persons within State and local criminal justice systems.[44] Also, drug abusers suffering from medical conditions may not be discriminated against in admission to, or treatment by, public or private general hospitals that receive any form of Federal support.[45]

Research

NIDA is authorized to make available research grants aimed at improving drug maintenance techniques or programs[46] and for other relevant purposes.[47] Research thus far undertaken has focused on improving understanding in the field of effective methods of prevention and control of drug abuse.[48] In 1976 the act was amended to encourage and promote, among other things, research and develop-

[30] 21 U.S.C.A. §1177(a) (1972 and Supp. 1980).
[31] Elaine M. Johnson, deputy director, Division of Community Assistance, NIDA, interview, Rockville, Md., Dec. 7, 1979 (hereafter cited as Johnson Interview).
[32] 21 U.S.C.A. §§1176, 1177 (1972 and Supp. 1980).
[33] *Id.* §1192(b) (Supp. 1980).
[34] *Id.* §§1179(a)–(c), 1192(b)(2) (1972 and Supp. 1980).
[35] *Id.* §1192(a)(2) (Supp 1980) and Susan Latcher, Communications Services Branch Chief, NIDA, telephone interview, Rockville, Md., Dec. 12, 1979 hereafter cited as Lachter Interview).
[36] NIDA Annual Report, p. 10.
[37] 21 U.S.C.A. §1177 (1972 and Supp. 1980).
[38] *Id.* §1176.
[39] NIDA Annual Report, p. iii.
[40] Ibid., p. 18.
[41] 21 U.S.C.A. §1176(e)(Supp. 1980) and Lachter Interview.
[42] 21 U.S.C.A. §1176(e)(5)(B) requires the State to provide assurances in its State plan that the State's prevention and treatment programs will be designed to meet the needs of women, the elderly, and minors.
[43] NIDA Annual Report, p. 8.
[44] 21 U.S.C.A. §1177(a)(3) (1972).
[45] *Id.* §1174 (Supp. 1980).
[46] 21 U.S.C.A. §1177(a)(5) (Supp. 1980).
[47] NIDA, Research Grants Program Announcement of Areas of Special Interest, February 1978.
[48] NIDA Annual Report, p. iv.

ment related to synthetic analgesics, antitussives, and other nonaddictive or less addictive drugs.[49]

Training

The National Drug Abuse Training Center is intended to "develop, conduct and support a full range of treatment programs relating to drug abuse functions."[50] The services and facilities of the training center are authorized to be made available to Federal, State, and local government officials and staff; to medical and paramedical personnel and educators; and to others, including drug dependent persons.[51]

Eligibility

State and local governments must meet specific eligibility criteria to obtain NIDA funds under statewide service contracts and formula grants. Special Projects and Statewide Service Contracts and Grants

Special project grants and contracts are awarded to public and private nonprofit and for-profit agencies, organizations, institutions, and individuals for the following:[52]

(1) Training projects;

(2) Vocational rehabilitation, counseling, and education services;

(3) Establishment of programs within State and local criminal justice systems (but not law enforcement activities;

(4) Research; and

(5) Establishment of programs for the general public.

Grants and contracts may be approved by NIDA only if they meet basic standards for the provision of services, administration of funds, monitoring, and evaluation and provide for treatment and treatment support activities as cited above.[53] Grants and contracts requested by States through their single State agencies under the provisions of the statewide service contracts/grants program must be evaluated in relation to the plan prepared under the formula grant program.[54]

State Formula Grants

Each State (including the District of Columbia and U.S. territories) is entitled to grants based on relative population, financial need, and the need for more effective conduct of functions.[55] NIDA has a responsibility to review all grants made for research, training, treatment, and prevention functions.[56]

The law further requires that States wishing to obtain grants must develop State plans which provide, among other things, for the following:[57]

(1) Establishment of a single State agency as the sole agency for preparing and administering the plan or for supervising the preparation and administration of the plan,

(2) Evidence to the effect that the designated agency has or will have the authority to carry out the plan;

(3) Establishment of a State advisory council;

(4) Description of the drug abuse prevention and treatment program to be undertaken by the State or carried out within the State;

(5) Detailed needs assessment and plan to meet the identified needs, with the specific identification of the needs and plans to meet the needs of women, the elderly, and minors under 18 years of age, such survey to be coordinated with the alcohol abuse survey;

(6) Provisions for program coordination, particularly in urban areas;

(7) Provision for participation in the preparation and administration of the State plan by political subdivisions in the State;

(8) Administration, reporting, evaluation, and analysis of the plan and the programs for which it provides;

(9) A complete inventory, to the extent feasible, of all public and private resources available in the State for the purpose of drug abuse prevention and treatment, including programs funded by State and local laws;

(10) Provision for coordination with local drug abuse planning agencies, with State and local alcohol abuse agencies, and with State and local health planning agencies; and

[49] Pub. L. No. 94-237, 90 Stat. 248 (1976) and amended Pub. L. No. 95-461, 92 Stat. 1268 (1978); Pub. L. No. No. 96-181, 93 Stat. 1315 (1980) (codified at 21 U.S.C.A. §1193 (Supp. 1980)).
[50] 21 U.S.C. §1179 (1976).
[51] *Id.* §1179(c).
[52] 21 U.S.C.A. §1177 (1972 and Supp. 1980).
[53] *Id.* §1177(c)(1)-(4) and Johnson Interview.
[54] 21 U.S.C.A. §1177(c)(2) (1972 and Supp. 1980).
[55] *Id.* §1176(c)(1)(A).
[56] *Id.* §1194 (Supp. 1980).
[57] *Id.* §1176(e) (1972 and Supp. 1980).

(11) Inclusion of a needs assessment of the severity of the drug abuse problem in urban and rural areas.

The NIDA program and its enabling legislation encourage the involvement of other federally sponsored service-providing agencies in national drug abuse initiatives. The legislation authorizing drug abuse prevention and treatment programs specifically encourages certain other Federal and State programs to coordinate with NIDA programs; community mental health centers; Public Health Service facilities; and State mental health programs.

Community Mental Health Centers

Community mental health centers are required to provide, within 3 years of the center's establishment, prevention and treatment programs for rehabilitation of drug addicts and abusers, as well as others who have drug abuse or drug dependence problems, who live in the center's catchment area.[58]

Public Health Service

Where there is sufficient need, as determined by NIDA, for drug abuse treatment and rehabilitation programs, such programs shall be established in Public Health Service facilities.[59] NIDA is also authorized to enter into agreements with the Administrator of Veterans' Affairs, the Secretary of Defense, and other Federal department or agency heads, to provide treatment and care in Public Health Service hospitals and medical facilities to drug addicts and other persons with drug abuse and other drug dependence problems who are in areas served by such hospitals or facilities.[60]

State Mental Health Programs

The 1972 Drug Treatment Act amended the Public Health Service Act to require that State plans for the provisions of public health services must "provide for services for the prevention and treatment of drug abuse and drug dependence, commensurate with the extent of the problem, and include provisions for (1) licensing or accreditation of facilities in which treatment and rehabilitation programs are conducted for persons with drug abuse and other drug dependence problems, and (2) expansion of State mental health programs in the field of drug abuse. . .and other prevention and treatment programs in the field. . . ."[61]

NIDA imposes no specific eligibility requirements on individual clients for participation in NIDA-sponsored or funded drug abuse prevention and treatment programs. Individual community-based programs may impose their own eligibility requirements such as residence within the program's catchment area and suitability of the type of treatment.[62]

Funding

The National Institute for Drug Abuse budget for FY 1978 was $262 million; for FY 1979, $272 million; and for FY 1980, about $274 million. [The 1980 budget above was based on a Congressional continuing resolution which maintained the NIDA budget at the fiscal year 1979 level, except for the addition of $2 million for certain mandated programs.[63]]

The fiscal year 1978 budget is included in the national drug abuse treatment utilization survey (NDATUS—an annual survey of all known drug abuse treatment units) which revealed that a total of more than $518 million was invested in drug abuse treatment services nationally for that year.[64] Of the 420,000 treatment "slots" provided, NIDA funded approximately 95,000.[65]

[58] 42 U.S.C.A. §2689(b)(1)(B)(V)(II) (Supp. 1980).
[59] 42 U.S.C. §257(a) (1976).
[60] *Id.* §257(c).
[61] 42 U.S.C. §246(d)(2)(K) (1976).
[62] Norton Interview.
[63] Sandy Smith, Division of Financial Management, ADAMHA, telephone interview, Rockville, Md., Dec. 11, 1979.
[64] NIDA Annual Report, p. 10.
[65] Ibid.

Department of Defense

Descriptions of the advocacy programs in the Department of Defense are included in this section. The Navy program, which has been extended to include family advocacy, is described in greatest detail. The child advocacy programs of the Army and Air Force are also included because of their potential for expansion in providing for the problems of spouse abuse. Two spouse abuse programs currently operating on military bases are also described.

Department of the Navy, Family Advocacy Program

The family advocacy program (FAP) is a new effort of the Department of the Navy designed to provide comprehensive services to Navy and Marine Corps families and unmarried service members in cases of suspected or confirmed abuse, neglect, sexual assault, and rape.[1] The program includes prevention, identification, intervention, treatment, and followup.[2] The current Bureau of Medicine and Surgery (BUMED) instruction provides policy guidelines for the Navy's FAP, as well as a program manual for implementation at the local level.[3] Because each naval command is unique in its relationship with the surrounding civilian community, the instruction allows for command flexibility, as well as setting overall standards for implementation.[4]

The current FAP effort is an outgrowth of the Navy Medical Department's spouse abuse reporting and child advocacy programs.[5] In 1976 BUMED issued an instruction on child care advocacy that was mandatory to all medical facilities.[6] Additionally, in 1976 BUMED required medical facilities to devise a spouse abuse reporting system.[7] In 1977, to reflect a broadening focus in the Navy, the child advocacy program was changed to a family advocacy program. The central child abuse and neglect registry also was revised to become a family advocacy central registry in which all forms of abuse and neglect were reported.[8] Despite the name change, "the impact at the local level was minimal."[9] Additionally, four pilot programs were established to determine the elements of a successful, comprehensive, family advocacy program.[10] The programs were "monitored and modified" accordingly.[11] In 1978 an Office of the Chief of Naval Operations (OPNAV) instruction about sensitive handling of rape and sexual assault cases was issued.[12] In 1979 the current FAP instruction was issued. This instruction reflects the knowledge obtained from the pilot programs and from relevant research and statistical data. The instruction incorporated the previous BUMED instructions on child advocacy, spouse abuse reporting, and sensitive handling of sexual assault victims.[13] The current instruction mandates that major medical facilities implement a FAP in accordance with the instruction. It is also applicable to the Marine Corps because the Marine Corps, not having separate medical facilities, utilizes naval facilities. The program is designed to interface with appropriate military and civilian agencies in the provision of comprehensive services and is intended to function as part of an overall military and civilian individual and family services program.[14] Currently, major medical facilities are selecting representatives to initiate this family-oriented effort.

Organizational Structure

The family advocacy program is in the Allied Health Division of the Bureau of Medicine and

[1] Lt. (jg.) Serge Doucette, Head, Family Advocacy Program, Bureau of Medicine and Surgery, Department of the Navy, interview in Washington, D.C., Dec. 12, 1979 (hereafter cited as Doucette Interview).

[2] Lt. (jg.) Serge Doucette, Testimony before the Select Education Subcommittee of the House Education and Labor Committee, U.S. Congress, Washington, D.C., July 10, 1979, p. 5 (hereafter cited as Doucette Testimony).

[3] U.S., Department of the Navy, Bureau of Medicine and Surgery, Family Advocacy Program Instruction 6320-57, July 11, 1979 (hereafter cited as BUMEDINST 6320.57).

[4] *Id.*, §9.

[5] Doucette Interview.

[6] U.S., Department of the Navy, Bureau of Medicine and Surgery Instruction 6320.53, Feb. 4, 1976 (hereafter cited as BUMEDINST 6320.53).

[7] U.S., Department of the Navy, Bureau of Medicine and Surgery, NOTE 6320, Nov. 19, 1976.

[8] Doucette Testimony, p. 2.

[9] Ibid.

[10] Doucette Interview.

[11] Doucette Testimony, p. 2.

[12] U.S., Department of the Navy, Office of the Chief of Naval Operations Instruction 6300.1, Aug. 16, 1978.

[13] Douchette Interview.

[14] Ibid.

Surgery of the Naval Medical Department. Broad policy is established by the Chief of the Bureau.[15] The head of the family advocacy program is responsible for ensuring establishment of a FAP in accordance with the instruction, assisting local commands in implementing a program overseeing the "function of the FAP at all BUMED activities," maintaining statistical reports on suspected cases of abuse and neglect and a central registry on established cases, and submitting recommendations to the Chief of BUMED.[16]

The instruction mandates the creation of a Central Family Advocacy Committee (FAC) divided into the following three working committees: 1) Child Abuse/Neglect, 2) Spouse Abuse/Neglect, and 3) Sexual Abuse/Neglect.[17] Membership on the Committee consists of representatives of the Surgeon General, Judge Advocate General, Naval Personnel Command, Commandant of the Marine Corps, Chief of Chaplains, and other appropriate commands.[18] The person charged with the overall responsibility of the Committee is to submit recommendations on the program management and expansion to the Chief of BUMED.[19] The working committees convene monthly to review and make recommendations for disposition of cases submitted to the central registry.[20]

At the installation level, the commanding officers of naval medical centers and hospitals carry responsibility for implementing the BUMED/FAP instruction[21] by establishing local policies and directives, designating a social worker or senior member of the command as family advocacy representative (FAR), and establishing a local family advocacy committee.[22]

The FAR has responsibility for "implementing and managing" the local FAP.[23] Currently, FARs have been designated. However, they must share their time between creating the new FAP and their other assigned responsibilities.

On a daily rotating basis a duty family advocacy representative (DFAR) is designated to have responsibility for assisting medical personnel and coordinating services provided in all cases of suspected abuse, neglect, sexual assault, or rape.[24]

Membership of the family advocacy committee consists of a chairman, pediatrician, gynecologist, psychiatrist or clinical psychologist, pediatric nurse, health care administrator, and, if available, a lawyer, chaplain, dental officer, and social worker.[25] The local FAC is divided into three working committees similar to their counterparts at BUMED. The committees meet at least once a month to review all suspected cases of maltreatment to assure that appropriate case decisions are made. Additionally, the committees evaluate the suspected and established maltreatment cases, report them to the chief of BUMED, and make program management recommentations.[26] The committees also must establish local reporting procedures in accordance with the Privacy Act of 1974.[27]

Naval regional dental centers and clinics are directed to develop local policy and directives, reporting procedures, and designate a dental officer to sit on the local FAC of the supporting medical facility.[28]

Benefits

Local programs provide both prevention and treatment in suspected cases of abuse, neglect, sexual assault, and rape.

Administrators of these programs are instructed to use the medical model of primary, secondary, and tertiary intervention in designing treatment and prevention programs.[29]

Primary intervention methods are directed to groups with a high-stress potential associated with "normal family life." Specifically identified are high school students, newlyweds, expectant couples, and individuals or families facing frequent deployments or separations. Parenting and family life programs for these groups provide support that might mitigate their high-risk potential. A primary prevention program may include evaluating child care, health, dental, recreational, and religious facilities and pro-

[15] BUMEDINST 6320.57 §7a.
[16] *Id.* (7)(b).
[17] *Id.* §7c(3).
[18] *Id.* §7a.
[19] *Id.* §7c(1).
[20] *Id.* §7d.
[21] *Id.* §7e.
[22] *Id.* §8a.
[23] *Id.* §8a(2).
[24] *Id.* §3 of Enclosure (1).
[25] *Id.* §8a(3).
[26] *Id.* §82(5).
[27] *Id.* §2 of Enclosure (1) subsection 3c.
[28] *Id.* §8b.
[29] BUMEDINST 6320.57 §4 of Enclosure (1) §3.

grams on military bases to determine their effectiveness at meeting the needs of military families.[30]

Secondary intervention is directed at families or individuals who are identified as "at-risk" for maltreatment, but have not yet experienced abusing and/or neglecting behavior.[31] The cost effectiveness of developing a strong program directed at this level of intervention is stressed.[32] Services are focused on assisting families to overcome areas of dysfunction that have placed them in the high-risk category.[33] The manual suggests settings in which high-risk families and individuals can be identified, situations conducive to creating conflict that can often indicate high-risk factors, and identifies high-risk groups.[34] At the secondary intervention level, outreach through public education campaigns is used to raise the level of awareness about potential for maltreatment and to encourage individuals and families to seek help before abuse or neglect occurs.[35]

Tertiary intervention is directed at individuals and families where abuse or neglect has been established. It is based on the assumption that abusing and neglecting families are often multiproblem families.[36] Initially, the major thrust of FAPs was at this level of intervention. Yet, intervention is not limited to this level.[37] To successfully carry out this model of intervention, the FAR is asked to have a working knowledge of the available military and civilian resources in the community.[38] Treatment and support services in abusive situations may include the following:

(1) Emergency short-term or long-term placement for children and spouses;
(2) Voluntary day care, both crisis-oriented and ongoing;
(3) High-risk clinics in the Department of Pediatrics for medical surveilance;
(4) 24-hour crisis hotlines;
(5) Homemaker services;
(6) Home visits by community health nurses, Navy Relief Society visiting nurse, and trained volunteers;
(7) Parent education classes and groups;
(8) Mental health services to individuals and families;
(9) Alcohol treatment services;
(10) Parents Anonymous groups;
(11) Family planning services;
(12) Volunteer services including transportation, emergency child care, and lay therapist programs; and
(13) Special education or assistance classes in schools.[39]

Legal and Clinical Services

The local FAR is responsible for working with military, State, and local judicial systems to define geographic areas that are exclusively the domain of the military base and areas that are under concurrent jurisdiction of the military, State, and local judicial systems.[40] The FAR is expected to establish the specific roles and responsibilities for various military and civilian agencies in responding to abuse and neglect cases in the military, and to establish the appropriate procedure for being responsive.[41]

The philosophy of the program is geared toward treatment rather than prosecution.[42] Intervention is seen as most effective when directed toward maintaining the family unit during treatment.[43] When it has been determined that the abuser should be prosecuted, prosecution can be conducted by either military or civilian authorities. When prosecution is necessary, the FAR continues to "assume an active and useful role to the victims, the perpetrator and the family unit."[44]

Counseling

Military members suspected of abuse or neglect cannot be interviewed without a preliminary warning, unless the interview pertains solely to the specific emergency medical situation.[45] Subsequent interviews with military personnel suspected of abuse or neglect cannot transpire until appropriate military and civilian legal authorities have been contacted and subsequent legal activities have been coordinated.[46] The decision to take judicial, nonjudi-

[30] *Id.* §4 of Enclosure (1) §3b(4).
[31] *Id.* §4 of Enclosure (1) §3b.
[32] *Id.* §3b(2).
[33] *Id.*
[34] *Id.* §3b(1)(c).
[35] *Id.* §3b(1)(a).
[36] *Id.* §3a(2).
[37] *Id.* §3a.
[38] *Id.* §3a(1).
[39] *Id.* §§4b(1)(a–m).
[40] *Id.* §12(2)(a).
[41] *Id.* §12(2)(b).
[42] *Id.* §12(2)(c) (4–5).
[43] *Id.* §12(2)(c)(4).
[44] *Id.* §12(2)(c)(5).
[45] *Id.* §12(4).
[46] *Id.*

cial, or administrative action is made by the commanding officer and convening authorities.[47] In making the decision, the treatment and prognosis formulated by medical and dental personnel are considered.[48] To assist in the interviewing process, an outline for conducting interviews and obtaining a social history is contained in the BUMED instructions.[49]

Reporting and Recording

Reporting of incidents of suspected or known abuse, neglect, sexual assault, or rape must be consistent with applicable State and local laws.[50] All military agencies, departments, and individuals within the geographic area served by the military facility are encouraged to report identified incidents of suspected or established abuse or neglect directly to the FAR, which will then report the incident to the appropriate local agency.[51]

The instruction requires that all suspected or established abuse or neglect cases identified in the emergency room of the local medical facility be reported immediately to the FAR.[52] Medical facility personnel are to notify the FAR of all cases of suspected or established abuse or neglect that have come to their attention.[53] Although not mandated, other military agencies and personnel, as well as civilian agencies, are encouraged to report cases of suspected or established maltreatment to the FAR for followup.[54] The FAR is instructed to work with these agencies to encourage reporting and to provide appropriate followup services.

Reports to the central registry are sent after a diagnosis has been made by the appropriate working committee. Identifying information is provided to the central registry only in cases of established abuse or neglect. The reporting of suspected cases to the central registry is done for statistical and planning purposes. Unfounded incidents are not reported.[55]

Eligibility

Active duty and retired military persons and their families are eligible for the full range of medical and nonmedical social services that the Navy FAP provides. Because the family advocacy program is a Navy medical service, the eligibility criteria for this program are the same as the eligibility criteria of other medical services provided by the Navy. Due to the limited resources at some medical facilities, the family advocacy programs rely heavily on the use of civilian resources. When civilian resources are used, the eligibility criteria of the particular resource used is applicable. When a civilian medical resource is used, active duty military members and their families in most cases are eligible for CHAMPUS, a military insurance program.[56]

Funding

No funds are earmarked by Congress in the Defense Department budget for the Navy's family advocacy program. The Navy has designated eight positions in the Bureau of Medicine and Surgery for staffing four pilot family advocacy programs. Additionally, funds are tagged for the family advocacy head at the Bureau of Medicine and Surgery. For fiscal year 1981, BUMED requested 32 additional positions for staffing 16 additional family advocacy programs at major naval medical facilities. During the study period, existing naval resources were used to implement the current BUMED family advocacy program instruction.[57]

Department of the Army

(As of June 1980, the Army did not have a spouse abuse intervention program.)

Department of the Air Force

(As of June 1980, the Air Force did not have a spouse abuse intervention program.)

Battered Spouse Shelter Program, Fort Campbell, Kentucky

In 1977 the Army social work service at Fort Campbell, Kentucky, took a close look at the problem of battered spouses. Although a few battered women came to the social work clinic for counseling, it became apparent that many more women were not seeking help for two basic reasons:

(1) The women did not know of the social work clinic and were not being referred to the clinic by other services; and

[47] *Id.* §12(5)(b).
[48] *Id.*
[49] *Id.*
[50] BUMEDINST 6320.57 §8 of Enclosure (1) §2a.
[51] *Id.*
[52] *Id.* §8(2)(a)(1)(b).
[53] *Id.* §2a(2).
[54] *Id.* §8(2)(a)(3,4).
[55] *Id.* §8(2)(b).
[56] Doucette Interview.
[57] *Id.*

(2) When a battered wife did come to the clinic, there were no services available to meet her immediate needs.

To gain command support for the establishment of a shelter program, the social work service staff began a public awareness campaign to groups of wives, church groups, newspapers, and radio programs. As a result of these efforts, the commanding general issued a directive to begin plans for a shelter.

In 1978 a small shelter was opened in unutilized space in the Army hospital complex at Fort Campbell, Kentucky. An initial grant of $500 was received from the Post Officers Wives Club. Furnishings were obtained through supply channels and wives club donations. Through an agreement with the food service and the treasurer's office, vouchers, signed by a social worker, were used in lieu of cash in the mess hall.

A legal entity was needed for holding and distributing funds. A tax-exempt organization, the Women's Protective Service, was formed and officially authorized to operate on the post.

The shelter program has limited capacity and resources. Maximum length of stay in the shelter is 7 days. Meals are provided in the hospital dining facility. No transportation is provided to the shelter; however, a fund is available to pay bus fare for victims needing emergency transportation. Counseling is provided through the Army social work service.

Referrals come from many sources: the emergency room, other hospital clinics, local agencies, chaplains, the unit commanders, and friends. During duty hours a battered wife may be seen by any staff member of the social work service staff; she will be referred to a supervisor if shelter is needed. During nonduty hours the behavioral science officer, on call 24 hours a day, decides whether shelter is required.

In 1978, 23 women and 1 man and their children utilized the shelter for an average stay of 1.5 nights. In 1979, 21 women with their children used the shelter. Demographic data for 1979 indicates that most of the wives served are 18–24 years of age while their husbands tended to be older and were generally in the lower military ranks. Most families lived off-post and were married for less than 5 years. The number of times abuse occurred within the family was found to correlate with the number of years of marriage.[1]

[1] Kathy Raiha, social work officer, Fort Campbell, "I Can't Go Home Tonight," and telephone interview, Nov. 18, 1979.

Spouse Abuse Program, McChord Air Force Base, Washington

Approximately 2 years ago, responding to a need for services to victims of spouse abuse, the chaplain services and the health clinic of McChord Air Force Base, working with the Tacoma, Washington, Women's Shelter, began to formalize their efforts in the area of domestic violence. A letter to the base commander requested approval for sponsorship of a program to increase the level of awareness of domestic violence problems on the base and advertise the availability of resources for the victims of domestic disputes. This request received the approval of the base commander, wing commander, and NCOs. A spouse abuse committee was established with representatives from the Air Force base clinic, security police, judge advocates' office, social actions office, chaplain service, and the Tacoma Women's Shelter. The Committee decided to focus on three areas of need and designed a program to meet these needs: treatment of victims, resource information for families, and education for base personnel.

Treatment for victims of domestic violence is now available through ongoing therapy sessions held at the mental health clinic on the base. Case facilitators for the groups include nurses, psychologists, and psychiatric social workers. Groups are held weekly. Shelter service is available, when necessary, through the Tacoma Women's Shelter.

The spouse abuse committee sponsors workshops and seminars in educating new commanders, first sergeants, and security police in the issues involved in domestic violence. These workshops are presented by the members of the spouse abuse committee to promote greater understanding of the problem of domestic violence on the base and of the resources available to address them.

Information concerning the spouse abuse program is advertised reguarly through the unofficial base newspaper. Cards have been printed that advertise a 24-hour hotline number at the Tacoma Women's Shelter and the names and numbers of the representatives on the spouse abuse committee. The military security police distribute the cards when responding to domestic disputes.

No new funding from the military has been made available for the operation of this program; rather, all services are provided through existing resources.[1]

[1] All information regarding the spouse abuse program at McChord AFB was collected via a telephone interview with Captain Phillips, Chief of the Mental Health Clinic, McChord AFB, with the permission of Maj. Louis W. Rosato, Clinical Consultants Division, Office of the Surgeon General, USAF.

Social Services for Low-Income Persons and Public Assistance Recipients (Title XX)

Social services for low-income persons and public assistance recipients are authorized by Title XX of the Social Security Act of 1935, as amended.[1] Title XX repeats and consolidates the former service programs for recipients of Aid to Families with Dependent Children (AFDC) under Title IV-A of the Social Security Act and the service programs for recipients of Aid to the Aged, Blind, or Disabled under Title VI of the Act.[2]

Under Title XX, grants are made to the States to enable them to provide social services to recipients of public assistance benefits under the various titles of the Social Security Act and to certain other low-income persons.[3] Title XX services must be directed at the achievement of one or more of the following goals.[4]

(1) Achieving or maintaining economic self-support to prevent, reduce, or eliminate dependency;

(2) Achieving or maintaining self-sufficiency, including reduction or prevention of dependency;

(3) Preventing or remedying neglect, abuse, or exploitation of children and adults unable to protect their own interests, or preserving, rehabilitating, or reuniting families;

(4) Preventing or reducing inappropriate institutional care, home-based care, or other forms of less intensive care; or

(5) Securing referral or admission for institutional care when other forms of care are not appropriate, or providing services to individuals in institutions.

States receive a formula grant, to be matched by State funds, to provide for the administration and provision of social services.[5] States are given broad discretion to define the services they provide, as Title XX does not mandate the provision of any specific services.

[1] 42 U.S.C.A. §1397a (Supp. 1979).

[2] The Titles I, IV-A, X, XIV and XVI social services programs remain in effect for Puerto Rico, Guam, and the Virgin Islands. 42 U.S.C.A. §1397 et. seq. (Supp. 1980) (amending 42 U.S.C. sections 602, 603, 604, 606, 622 and other sections of Title 42 (1970)). However, Title XX does provide funds to supplement the provision of services under those programs (42 U.S.C. §1397a (a)(2)(D) (1976)).

Organizational Structure

Federal Administration

The Title XX social services program is administered at the Federal level by the Office of Human Development Services (OHDS), Department of Health and Human Services. Policy guideline development and program support are provided centrally through OHDS.

Ten regional offices monitor the operations of Title XX State programs in their region. They also (1) review State expenditures and estimates quarterly to determine their reasonableness, (2) review State administrative plans prior to approval by the Secretary, and (3) review State service plans. Regional offices provide coordination with other Federal programs and private sector agencies. They also offer training and technical assistance to their State agencies, upon request.

State Administration

Title XX requires each State to designate a State agency to be responsible for the administration of the social services program or to supervise the administration of the program.[6] The State agency, regardless of whether it administers or supervises administration of the program, is responsible for the development of the comprehensive services plan.

The designated single State agency conducts needs assessments to determine the services priorities and establishes procedures for determining client eligibility. It also provides or arranges for the provision of services to eligible recipients, evaluates the effectiveness of services provided, and otherwise maintains accountability for Federal, State, and local funds used in the program.

Local Administration

Within the State services plan, the State (or county public agencies with State approval where the State has a county-administered system) deter-

[3] 42 U.S.C. §1397a(a)(4)(A)(B)(C)(D) (1976).

[4] *Id.* §1397.

[5] 42 U.S.C.A. §1397a(a)(2)(A)(ii) (Supp. 1979).

[6] 42 U.S.C. §1397(b)(d)(1)(C) (1976).

mines which of the services will be provided directly, through public social service agency staff, or purchased through contracts within local public and/or private nonprofit agencies. Once determined, contracts are let and services provided. Monitoring of contracts remains the responsibility of the designated State agency.

Benefits

State Assistance

Title XX annually authorizes the expenditure of Federal funds to assist States in the provision of social services to low-income and public assistance recipients and other special populations at risk.[7] The funds are distributed to the States under a formula that establishes a State allocation percentage based on a State's population, divided by the population of all the States.[8]

Title XX funds may be utilized by the State to assist in defraying the costs of administering the social services program (including planning and evaluation), training or retraining personnel to provide services under the program (including short- and long-term training at educational institutions), and for the costs of providing or purchasing services for eligible recipients.[9]

The Federal share of the costs for any Title XX expenditure cannot exceed the following percentages, subject to the limits of the State allocation:

(1) 75 percent of the costs for administration, training, and services directed at the achievement of one or more of the goals of the Title XX programs;[10] and

(2) 90 percent of the costs for the provision of family planning services.[11]

(3) 100 percent of the costs for day care.[12]

HEW may make technical assistance available to the States for their services program planning, reporting, administration, and evaluation.[13]

The Secretary of Health and Human Services is prohibited from providing a Title XX payment to a State if the expenditure is not for the provision of a service, or is not for the provision of a service directed at one of the specific goals described in the law.[14]

Limitation on State Assistance

While Title XX provides the States broad discretion in defining the social services to be made available to eligible recipients, it also limits their discretion by requiring that:

(1) No less than 50 percent of the funds allocated to the State must be utilized to provide services to public assistance (Titles IV–A, XVI and XIX of the Social Security Act) recipients;[15] and

(2) Expenditures for any of the following items are prohibited:

(a) The provision of medical or any other remedial care, other than family planning, unless:

(i) It is an integral but subordinate part of another service, and

(ii) Federal assistance for the service is not available under Title XIX of the Social Security Act (medicaid);[16]

(b) The purchase, construction, or major modification of any land, building, or fixed equipment;[17]

(c) In-kind goods or services provided by a private entity;[18]

(d) Services purchased with privately donated funds, unless:

(i) The funds are transferred to the administrative control of the State, and

(ii) The funds are donated without restriction as to use, other than a restriction on the type of services that the funds may be used for, and the donee is not the provider of that type of service;[19]

(e) The provision of room or board, including emergency shelter except when provided for a period of not more than 6 consecutive months as an integral but subordinate part of another service;[20]

(f) Day care services, unless:

(i) They meet the standards of national standard-setting organizations, or

[7] 42 U.S.C.A. §1397a(a)(2)(A)(ii) (Supp. 1979).
[8] *Id.* §1397a(a)(2)(A)(i).
[9] *Id.* §1397a(a)(3)(A)(B).
[10] *Id.*
[11] *Id.*
[12] Adoption Assistance and Child Welfare Act of 1980, Pub. L. No. 96–272, §202, 94 Stat. 500 (to be codified at 42 U.S.C. §1397a).
[13] 42 U.S.C. §1397(e)(b) (1976).
[14] *Id.* §1397–1397a(a)(3)(A)(B).
[15] *Id.* §1397a(4)(A)(B)(C)(D)(E).
[16] *Id.* §1397a(a)(7)(A).
[17] *Id.* §1397a(a)(7)(B).
[18] *Id.* §1397a(a)(7)(C).
[19] *Id.* §1397a(a)(7)(D)(i)(ii).
[20] *Id.* §1397a(a)(7)(E).

(ii) Meet the Federal day care standards.[21]

(g) Educational services that the State makes generally available without cost or regard to income;[22]

(h) Any service to an individual living in any hospital, skilled nursing facility, or intermediate care facility, any prison, or any foster family home, unless:

(i) the service is provided by an entity other than the hospital, facility, prison, or foster family home, and

(ii) is provided under the State's Title XX plan to persons who are not living in a hospital, facility, prison, or for the family home;[23]

(i) Cash payments as a service;[24]

(j) The provision of a service, by foster family parents, other than those designated to meet the special needs of a child.[25]

Recipient Benefits

Persons in a particular geographic area who are determined to be eligible for the receipt of Title XX social services in that area may receive any of the services included in the State's comprehensive service plan (CSP). Services provided under Title XX may include, but are not limited to:

child care services, protective services for children and adults, services for children and adults in foster care, services related to the management and maintenance of the home, day care services for adults, transportation services, training and related services, employment services, information and referral, and counseling services, the preparation and delivery of meals, health support services and appropriate combinations of services designed to meet the special needs of children, the aged, the mentally retarded, the blind, the emotionally disturbed, the physically handicapped, and alcoholics and drug addicts.[26]

General Services

The States are not required to provide any specific services. However, each State must provide at least one service directed at each of the five Title XX legislated goals and must also provide at least three services for supplemental security income (SSI) recipients.[27] Additionally, the State may provide information and referral services, family planning services, and any service directed at the goal of preventing or remedying neglect, abuse, or exploitation of children and adults unable to protect their own interests, to all persons without regard to any eligibility requirements.[28]

Eligibility

State Eligibility

To be eligible for participation in the Title XX program, the following is nesessary:

1. The State must prepare, and have approved by the Secretary of Health and Human Services, an administrative State plan for the provision of social services.[29] The State plan must include:

(a) Provisions for granting a fair hearing, before the appropriate State agency, to any person whose claim for benefits is denied or not acted upon with reasonable promptness or whose services were reduced or terminated;[30]

(b) Provisions for the maintenance of the confidentiality of applicant or client information;[31]

(c) The designation of a State agency to be responsible for the administration or supervision of the administration of the plan;[32]

(d) Provisions for the maintenance of personnel standards on a merit basis;[33]

(e) Provisions barring durational residency or citizenship requirements as a condition of eligibility for the receipt of services;[34]

(f) Provisions for the establishment or designation of a State authority to be responsible for establishing and maintaining standards for the operation of residential institutions, foster homes, and day care services (if the plan provides for the provision of services to persons living in institutions or foster homes, or the provision of day care services);[35]

[21] *Id.* §1397a(a)(9)(A)(i).
[22] *Id.* §1397a(a)(a)(10).
[23] *Id.* §1397a(a)(11)(A)(i)(ii).
[24] *Id.* §1397a(a)(12).
[25] *Id.* 1397a(a)(11)(B).
[26] *Id.* §1397a(a)(1).
[27] *Id.* §1397c(2)(B).
[28] *Id.* §1397a(6).
[29] *Id.* 1397b(d)(2).
[30] *Id.* §1397b(d)(1)(A).
[31] *Id.* §1397b(d)(1)(B).
[32] *Id.* §1397b(d)(1)(C).
[33] *Id.* §1397b(d)(1)(D).
[34] *Id.* §1397b(d)(1)(E).
[35] *Id.* §1397b(D)(1)(F)(G).

(g) Provisions putting the plan into effect for all political subdivisions of the State;[36]

(h) Provisions for State financial participation in the operation of the plan;[37] and

2. The State must have a comprehensive services plan that meets the following content and planning requirements:

(a) Content requirements include:

(1.) A statement of the objectives to be achieved under the program;[38]

(2.) A listing of services included in the plan, definition of the services, a description of the relationship of the services to the objectives to be achieved under the program, and a listing of the corresponding Title XX goal for each service. At least one service must be directed at each of the five Title XX goals, and at least three of the services specified in the plan must be provided to SSI recipients;[39]

(3.) A specification of the categories of services recipients, including any categories based on the income of the eligible recipients;[40]

(4.) A specification and description of the geographic areas in which services are to be provided and the nature and amount of services to be provided in each area;[41]

(5.) A description of the planning, evaluation, and reporting activities to be carried out under the program;[42]

(6.) A listing of the sources of funds to be used to carry out the program;[43]

(7.) A description of the organizational structure through which the program will be administered;[44]

(8.) A description of how the program will be coordinated with the AFDC, SSI, and medicaid programs, including the steps taken to assure maximum feasible utilization of services under the program to meet the needs of the low-income population;[45]

(9.) A detailed break-out of the estimated expenditures for services, including expenditures for each service, each category of recipients, each geographic area in which services are to be provided, and a comparison of the Federal and non-Federal expenditures for the provision of services included in the Services plan for the previous fiscal year;[46]

(10.) A description of the steps taken, or to be taken, to assure that the needs of residents of all geographic areas were taken into account in the development of the plan.[47]

(b) Planning requirements include:

(1.) The establishment of a date for the beginning of the services program year;[48]

(2.) The publication of a proposed services plan at least 90 days prior to the beginning of the services program year for dissemination to the general public;[49]

(3.) The solicitation and acceptance of public comments on the contents of the proposed plan for a period of at least 45 days after the date of publication;[50]

(4.) The publication of a final plan in a display advertisement, no earlier than 45 days after publication of the proposed plan, before the beginning of the services program year, which provides the same information as the proposed plan as well as an explanation of any differences between the proposed and final plans;[51] and

(5.) The publication and solicitation of public comments on any proposed amendment to the CASP, at least 30 days before the expected effective date of the amendment and the publication of the final amendment with an explanation of any differences between the proposed and final amendments;[52] and

(6.) The CASP must not propose or include the expenditure of any Title XX funds for any

[36] *Id.* §1397b(d)(1)(H).
[37] *Id.* §1397b(d)(1)(I).
[38] *Id.* §1397c(2)(A).
[39] *Id.* §1397c(2)(B).
[40] *Id.* §1397c(2)(C).
[41] *Id.* §1397c(2)(D).
[42] *Id.* §1397c(2)(E).
[43] *Id.* §1397c(2)(F).
[44] *Id.* §1397c(2)(G).
[45] *Id.* §1397c(2)(H).
[46] *Id.* §1397c(2)(I).
[47] *Id.* §1397c(2)(J).
[48] *Id.* §1397c(1).
[49] *Id.* §1397c(2).
[50] *Id.* §1397c(3).
[51] *Id.* §1397c(4).
[52] *Id.* §1397c(5).

of the purposes excluded under limitations on State assistance.[53]

Client Eligibility

Under Federal law, all public assistance recipients and certain other low-income persons are eligible for the receipt of Title XX social services.

Public Assistance Recipients

A State may provide services withoput a fee to all AFDC and SSI recipients; furthermore, those persons whose needs were taken into account in determining an AFDC or SSI recipients's eligibility are eligible to receive Title XX social services without cost.[54]

Low-Income, Fee-Paying Recipients

A person who is a member of a family whose monthly gross income exceeds 80 percent of the median family income for a family of four in the State and does not exceed 115 percent of the median income of a family of four in the State (adjusted for family size) may only receive specified Title XX services with the payment of a fee for the services received.[55]

Eligibility Without Regard to Public Assistance Status or Income

All persons regardless of whether they are public assistance recipients, and regardless of income, are eligible to receive the following Title XX services: information and referral services, family planning services, and services directed at preventing or remedying neglect, abuse, or exploitation of children and adults unable to protect their own interests.[56]

Group Eligibility. The State may determine a group of persons to be eligible to receive Title XX services if after considering certain factors it can reasonably conclude that at least 75 percent of all members of the group who receive the specific service have gross monthly incomes of less than 90 percent of the State's median income for a family of four (adjusted for family size). These factors are: the geographic area in which a specific service is provided; the characteristics of the community in which the service is provided; the nature of the services provided; the conditions of eligibility for receipt of the service, other than income; or any other factors surrounding the provision of a particular service.[57]

Funding

Title XX funds will be allotted to States according to amounts to be determined by indexing the preceding fiscal year's ceiling to the degree of change in the Consumer Price Index, up to an amount not to exceed $3.3 billion.[58]

[53] *Id.* §1397a.
[54] *Id.* §1397a(a)(5)(A).
[55] *Id.*
[56] *Id.* §1397a(a)(6)
[57] *Id.* §1397a(a)(14)(A).
[58] Adoption Assistance and Child Welfare Act of 1980, Pub. L. No. 96–72, §201(a)(b), 94 Stat. 500 (to be codified at 42 U.S.C. §1397a).

Appendix C

Analysis of the Domestic Violence Prevention and Services Act (H.R. 2977 and S. 1843)

Statement of the Problems Addressed

The "Finding and Purpose" sections of H.R. 2977 and S. 1843 are virtually the same. The congressional findings, as stated in both bills, are:

- There is a significant degree of violence within families;
- The reported incidence of domestic violence is much less than its prevalence;
- Domestic violence presents a major danger to law enforcement personnel responding to requests for assistance;
- Domestic violence affects families from all social and economic backgrounds; and
- The effectiveness of State laws and State and local programs designed to prevent domestic violence or provide assistance to victims is not readily ascertainable.

In response to these findings,it is the purpose of the bills to stimulate greater participation by the States, local communities, and private nonprofit organizations in efforts to prevent domestic violence and to provide emergency shelters and other forms of assistance to victims of domestic violence. Additional purposes of the bills are to provide technical assistance and training to domestic violence service providers, to establish a Federal interagency council to improve coordination of Federal programs related to domestic violence, and to provide information gathering and reporting programs related to domestic violence.

From an examination of the purpose statements of both H.R. 2977 and S. 1843, as well as the content of the bills, the clear emphasis on both pieces of legislation is on provision of assistance to State and local programs serving victims of domestic violence. Special emphasis is given to organizations providing immediate shelter to victims of domestic violence and dependents of the victims of domestic violence.

Although the legislative language does not explicitly indicate that the clear intent of both bills is to provide primary assistance to adult female victims of domestic violence and (where the circumstances apply) to their children, this intent is made clear in the introduction to S. 1843[1] and in various stages of debate on the passage of H.R. 2977.

[1] 125 Cong. Rec. S13,688, 13,693 (daily ed. Sept. 28, 1979) (remarks of Sen. Cranston and Sen. Javits).

Benefits

Program Assistance

Formula grants are the primary benefit provided by both the House and Senate versions of the Domestic Violence Prevention and Services Act. Both bills authorize the provision of grants to the States for development of ongoing operations, or the expansion of local public or private nonprofit organizations that provide services/activities to prevent domestic violence, or provide immediate shelter and other assistance to victims of domestic violence. The amount of the program assistance grant provided each State, by both H.R. 2977 and S. 1843, is determined by dividing a given State's population by the national population and then multiplying the result by the total grant appropriation.

Maximum Grants and Maximum Time Limits

The differences between H.R. 2977 and S. 1843 are the percentage of the total appropriation provided for program assistance, the minimum amount of the program assistance grant made available to the States, and the means by which program assistance grants are distributed.

Percentage of Appropriation Available for Program Assistance Grants

Under H.R. 2977 all program assistance is provided through grants to the States. The States are responsible for determining which local programs will receive funding assistance. The Federal legislation requires the States to allocate no less than 75 percent of their program assistance grants to private, nonprofit, community-based organizations. Funding priority must be given to programs that have demonstrated effectiveness, with particular emphasis to be given to shelters. The remaining 25 percent of the program assistance grant may be allocated to local public organizations serving the needs of victims of domestic violence. State entities are not eligible for funding with program assistance grants.

S. 1843 provides program assistance grants to local public and private nonprofit organizations by two means.

First, program assistance funds are provided through grants to the States. The States are responsible for determining which local programs will receive funding assistance. No less than 66-2/3 percent of the State's program assistance grant must be distributed to private, nonprofit, community-based organizations. Funding priority must be given to existing programs that have demonstrated their effectiveness. Special emphasis is placed on the funding of shelters through a requirement that no less than 75 percent of the State's program assistance grant must be distributed to shelters serving victims of domestic violence and dependents of victims. The remaining 33-1/3 percent of the State program assistance grant may be allocated to local public organizations serving the needs of victims of domestic violence. State entities are not eligible for funding with program assistance grants.

The second means by which program assistance grants are provided is through direct grants to local public and private nonprofit organizations. Direct grants are made by the Director of the National Center on Domestic Violence, which is established by the provisions of S. 1843. The amount of funds available for direct program assistance grants is limited to 25 percent of the total appropriation provided by Congress.

Summary of Program Assistance Grants

The following summarizes the respective provisions of H.R. 2977 and S. 1843 for program assistance grants:

Amount of program assistance made through State grants:

- H.R. 2977: 75 percent of the Federal appropriation.
- S. 1843: 60 percent of the Federal appropriation.

Percentage of the State program assistance grant allocated to private, nonprofit organizations:

- H.R. 2977: 75 percent of the State program assistance grant.
- S. 1843: 60 percent of the State program assistance grant.

Special emphasis or shelter funding:

- H.R. 2977: Requires priority to be given to shelters.
- S. 1843: Requires 75 percent of the State program assistance grant to be allocated to shelters.

Direct program assistance grants:

- H.R. 2977: No provisions.
- S. 1843: Allocates 25 percent of the Federal appropriation for direct program assistance grants.

Maximum program assistance grant:

- H.R. 2977: $50,000 per fiscal year or 25 percent of the annual budget of such organization or agency, whichever is less. Newly established agencies may

receive 50 percent of their annual budget, but no more than $50,000 per fiscal year.

- S. 1843: $50,000 per fiscal year.

Maximum funding period:

- H.R. 2977: 3 fiscal years.
- S. 1843: 3 fiscal years.

State Administrative Assistance

Both H.R. 2977 and S. 1843 authorize grants to the States to assist in the administration of the States' domestic violence programs. The States may also utilize the funding provided to prepare the application for program assistance grants and to assure active citizen participation in the planning and evaluation of the organizations receiving program assistance grants. H.R. 2977 also provides that the administrative grant may be used to develop and run a media campaign to increase public awareness of the problem of domestic violence and the availability of services for victims.

The total amount of administrative grant funds to be made available under each bill is 15 percent of the total appropriation under H.R. 2977 and 10 percent of the total appropriation under S. 1843. The minimum administrative grant available to a State under both bills is the greater of 0.5 percent of the administrative grant funds in the total appropriation or $7,000 per fiscal year under H.R. 2977, or $8,000 per fiscal year under S. 1843.

Federal Activities

Both H.R. 2977 and S. 1843 provide for two levels of Federal activity relative to domestic violence programming. On the first level specific responsibilities are given to the Department of Health and Human Services for coordinating and carrying out activities related to the administration of the Federal grant programs and otherwise promoting the prevention of domestic violence and the provision of assistance to victims of domestic violence. On the second level of Federal activity, both bills require the coordination of all Federal activities related to domestic violence.

The two bills have different approaches to the responsibilities given to DHHS and to the level of funding made available for its impact on Federal activities.

H.R. 2977 assigns specific responsibilities to DHHS by requiring the Secretary to designate a coordinator of all domestic violence programs administered by the Department. One of the programs is a national clearinghouse on domestic violence, to be operated in coordination with the child abuse clearinghouse operated by the National Center on Child Abuse and Neglect.[3] The specific responsibilities of the clearinghouse are to collect and disseminate information on programs relating to the prevention and treatment of domestic violence.

Additional responsibilities of the Secretary of Health and Human Services include making recommendations to Congress for changes in legislation related to domestic violence and assisting in the coordination of Federal domestic violence-related programs in conjunction with the Federal Interagency Council on Domestic Violence.

S. 1843 has a more detailed approach to the assignment of specific domestic violence responsibilities to DHHS. The bill establishes, within DHHS, a National Center of Domestic Violence to be headed by a Director appointed by the Secretary. The responsibilities of the Director of the National Center include:

- Administration of grants programs authorized by the bill;
- Coordination of all Federal domestic violence programs and activities in conjunction with the Federal Interagency Domestic Violence Council;
- Establishment and operation of a domestic violence information and resource clearinghouse responsible for:
  - —Collection, analysis, preparation, and dissemination of information relative to the prevention and treatment of domestic violence;
  - —Advocacy for the prevention of domestic violence and for the provision of assistance to victims of domestic violence; and
  - —Provision of technical assistance to persons or organizations interested in the prevention of domestic violence, or interested in the provision of immediate shelter and other assistance to victims of domestic violence.
- Development and operation of a national media compaign to increase public awareness of the problem of domestic violence and of the availability of programs for domestic violence victims. The Director is also given discretionary authority to establish a national hotline to provide information on existing programs in various parts of the Nation; and

[3] 42 U.S.C.A. §§5101-5106 (1976).

• The Secretary, through the Director, is authorized to make grants or enter into contracts to provide technical assistance, training, and outreach services to States, public agencies, and private organizations participating in the programs authorized by the bill.

The National Center is also responsible for informing interested parties of sources of funding other than those authorized by the bill.

Overall Coordination of Federal Domestic Violence Activities

Both H.R. 2977 and S. 1843 establish mechanisms for overall coordination of Federal activities related to domestic violence. The composition and assigned responsibilities of the Federal Interagency Coordinating Council, as established by both bills, are virtually the same.

The overlapping membership of the Council established in the two bills includes representatives of:

Department of Agriculture (Food Stamps);
Department of Defense;
Department of Housing and Urban Development;
Department of Justice (including the Law Enforcement Assistance Administration);
ACTION;
Community Services Administration;
Legal Services Corporation;
Appropriate institutes within the Alcohol, Drug Abuse, and Mental Health Administration, and
Five members of the general public appointed by the Secretary of Health and Human Services. (Such members are to be victims of domestic violence or persons with experience in providing services to victims of domestic violence.)

H.R. 2977 also includes on the Council representatives of State and local governments (the number of such representatives is not specified). S. 1843 authorizes the President to include on the Council representatives of other agencies.

The fundamental responsibilities of the Coordinating Council, as specified in both H.R. 2977 and S. 1843, are to identify, assess, and facilitate the coordination of all Federal activities related to domestic violence and to report recommendations for the coordination of Federal policy and the development of objectives and priorities for all Federal domestic violence programs. H.R. 2977 gives the council an advocacy responsibility; the bill states that the Council would be responsible for encouraging continuation and expansion of Federal support for domestic violence programs.

Federal coordination activities are funded from a fixed percentage of the appropriation authorized by H.R. 2977 and S. 1843. A maximum of 10 percent of the appropriation under H.R. 2977 and 5 percent under S. 1843 is set aside for Federal activities.

Benefit Recipients

Client Recipients

Neither H.R. 2977 nor S. 1843 provides direct benefits to clients. Rather, clients benefit from the services and activities provided under the program assistance grants.

Victims of domestic violence are eligible for services and activities funded by either H.R. 2977 or S. 1843. Both bills prohibit funded programs from imposing any income eligibility requirements. However, H.R. 2977 does require funded organizations seek to collect a fee for services provided in accordance with the client's ability to pay.

Program Assistance

To be eligible for a program assistance or an administration grant each State must submit an application, approved by the chief executive officer of the State, presumably the Governor, to DHHS for approval. Both H.R. 2977 and S. 1843 would require the State application to contain the following information:

• Provisions for the distribution of program assistance grant funds to local public and private nonprofit community-based organizations involved in preventing domestic violence or providing shelter and other assistance to victims of domestic violence and their dependents:

• Agreement to give special emphasis to the funding of nonprofit organizations directly serving victims of domestic violence, i.e., providers of immediate shelter and other forms of assistance. (H.R. 2977 requires the State to allocate no less than 75 percent of its program assistance grant to such organizations, and S. 1843 requires that no less than 66-2/3 percent be allocated to shelters);

• Procedures for the equitable distribution of program assistance funds within the State;

• Assurances to funded organizations of the anticipated future level of financial support, assuming the continuation of an adequate level of Federal funding of the domestic violence prevention and treatment program;

- Procedures for fiscal control and accountability for the use of Federal funds;
- Assurances that the confidentiality of client information will be maintained and that the address or location of a shelter for victims of domestic violence will not be disclosed at the request of such shelter, nor to be made public unless the director of the facility desires such information to be made public;
- Designation of a State agency to be responsible for administration of the domestic violence program authorized by the Federal legislation;
- Assurances for active citizen participation in determining the distribution of program assistance funds throughout the State, and that of local programs for their present or potential relevance to the prevention or treatment of domestic violence;
- Assurances that funded programs be administered and operated by staff with the appropriate skills, training or experience; and
- Agreement to comply with requirements for the submittal of reports, as requested by DHHS.

In addition to these requirements, which are the same in both bills, H.R. 2977 requires the State, as a condition of eligibility, to do the following:

- Provide technical assistance to organizations receiving program assistance funds to help those agencies obtain adequate levels of funding from a variety of sources; and
- Submit to the State legislature the same annual report required to be submitted to DHHS.

Benefits Delivery System

The systems for the delivery of benefits under both H.R. 2977 and S. 1843 are virtually the same. Chart C1 depicts the major elements of the delivery system at the Federal, State and local levels of government. Differences between H.R. 2977 and S. 1843 are noted in parentheses.

Funding

H.R. 2977 and S. 1843 both authorize the expenditure of $65 million over 3 years for domestic programs—fiscal year 1981, $15 million; FY 1982, $20 million; and FY 1983, $30 million.

The bills call for the same funding level, but allocate funds for specific purposes differently. The allocations would be:

State Program Assistance Grants

- H.R. 2977—75 percent of appropriated funds
- S. 1843—60 percent of appropriated funds

Direct Federal Program Assistance Grants

- H.R. 2977—No provision for such grants
- S. 1843—25 percent of appropriated funds

State Administration Grants

- H.R. 2977—15 percent of appropriated funds
- S. 1843—10 percent of appropriated funds

Federal Operations Grants

- H.R. 2977—10 percent of appropriated funds
- S. 1843—5 percent of appropriated funds

If the Federal appropriation equals the authorization, funding for domestic violence programming over fiscal years 1981–83 will be for Federal Operations:

- H.R. 2977
  FY 81—$1.5 million
  FY 82—$2.0 million
  FY 83—$3.0 million
- S. 1843
  FY 81—$0.75 million
  FY 82—$1.0 million
  FY 83—$1.5 million

Analysis of the allocation of funds by H.R. 2977 and S. 1843 (assuming full funding) reveals that S. 1843 assigns a greater proportion of total funds to direct support of programs serving domestic victims than H.R. 2977. The total allocation per fiscal year would be as follows:

- S. 1843*
  FY 81—$12.75 million
  FY 82—$17.0 million
  FY 83—$25.15 million
- H.R. 2977
  FY 81—$11.25 million
  FY 82—$15.0 million
  FY 83—$22.5 million

*Includes State program assistance and direct Federal assistance.

H.R. 2977 requires that a greater proportion of its State program assistance grant funds go to support of shelters serving victims of domestic violence than S. 1843.

- HR 2977**
  FY 81—$8,437,500
  FY 82—$11,250,000
  FY 83—$16,875,000
- S. 1843***
  FY 81—$5,994,000
  FY 82—$7,992,000
  FY 83—$11,988,000

**Requires 75 percent of program assistance funds to be expended in support of shelters.

***Requires 66-2/3 percent of program assistance funds to be expended in support of shelters.

*U.S. GOVERNMENT PRINTING OFFICE: 1982-0-522-037/7726